# King County Mental Health, Chemical Abuse and Dependency Services Division

# Substance Abuse Prevention and Treatment Annual Report

# 2013

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# Message From the Substance Abuse Treatment Coordinator

My first period of time as the Alcohol and Drug Coordinator in King County has provided amazing learning experiences. Undoubtedly, the most evident piece is how amazingly robust the chemical dependency treatment system is in King County and how much those who work in the system care. I have spent countless hours talking with providers and staff about what they do and how much passion they have to serve those in need. To say it is amazing is understatement.

The passion to serve is not lip service; it is shown in action and dedication every day. Not only is it the desire to serve, but to serve *better*. That is why the Substance Abuse Treatment and Prevention Annual Report (formerly the Chemical Dependency Performance Indicator Report – CDPIR) is so important. At the King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD), we are dedicated to making intelligent, data-driven decisions that tell us what we are doing well and what we need to improve on. Data tells us where the need is and what intervention is the most appropriate. Often times, this reinforces what we anecdotally know, but it also allows us to learn new, more effective ways to serve our community. To that end, our community is responsive and adapts to the needs of our people.

The future is ripe with challenges, but those challenges are truly opportunities. The Affordable Care Act (ACA) has allowed us to serve more people in need than ever before, and allows those in need to get more comprehensive care. Health care integration is right around the corner, and King County is dedicated to developing a model of care that lowers barriers to service and improves outcomes for all that we are fortunate to have contact with that have behavioral health needs.

Assistant Division Director, Prevention and Treatment Coordinator

# Community Prevention and Wellness

King County MHCADSD supported four community coalitions focused on preventing and reducing youth substance abuse and associated issues. As part of the statewide Community Prevention and Wellness Initiative, these coalitions work cooperatively with community members, providers, agencies, and school district personnel to provide prevention programming. Highlights from 2013 include the following:

## Central Seattle Drug Free Communities Coalition

- Held a community event to recognize drug prevention efforts in Central Seattle, with speakers that included U.S. Congressman Adam Smith and Steven Freng, Ph.D. of Northwest High Intensity Drug Trafficking Area (NW HIDTA).
- Integrated the drug prevention curricula, Project Alert and LifeSkills Training to reach students at Washington Middle School.
- Conducted the Guiding Good Choices program with parents of middle-school-aged children.
- Supported five youth groups at Washington Middle School and Garfield High School, with the youth leading positive, prosocial activities to engage their peers.

## Coalition for Drug-Free Youth

- Developed their community prevention coalition to ensure representatives from various sectors including business, media, parents, civic/volunteer/community groups, schools, youth/students, law enforcement, faith-based entities, healthcare, substance abuse treatment organizations, state/local/tribal government, and youth-serving organizations.
- Launched a media campaign to promote youth involved in positive, drug-free activities as well as to change the misperception that most youth use alcohol, tobacco, and other drugs.
- Supported youth prevention activities involving students from Cascade Middle School and Evergreen High Schools in Highline School District.

## SE Seattle P.E.A.C.E. Coalition

- Developed a comprehensive strategic plan that included a needs/resources assessment, action plan, and evaluation plan.
- Planned and delivered two major public awareness campaigns related to drug prevention. The first was on the consequences of providing alcohol to minors; the second focused on social norms messages tied into the national Above the Influence campaign.
- Engaged policy-makers to discuss prevention issues and coalition efforts. This included meetings with Senator Adam Kline, Representative Eric Pettigrew, and Western Washington US Attorney Jenny Durkin.
- Participated in community events and health fairs, including the Lao Khmu New Year event and the Rainier Beach Back to School Bash.

## Vashon Alliance to Reduce Substance Abuse

- Planned and coordinated an event aimed at older teens and young adults on Vashon Island called “Shine.” This was a storytelling and open mic event. The goals were to change community norms regarding drugs and to increase awareness around substance abuse prevention.
- Implemented a range of programs to support parents and families, including parenting education classes, parent workshops, parent coaching, playgroups, wraparound services, and support groups.
- Conducted Second Step with 7th and 8th graders at McMurray Middle School and provided youth opportunities to be involved in peer-led prevention activities.

All the coalitions collaborated with Puget Sound Educational Service District staff assigned to work in specific neighborhood schools. Coalition members and youth also participated in local, state, and/or national prevention conferences and events to stimulate information sharing and to promote use of effective prevention programs.

# King County Council Supports Recovery:
# Recovery and Resiliency Ordinance 17553 Passes King County Council Unanimously

King County Ordinance 17553 was passed unanimously by the King County Council in April 2013. The Ordinance directs the King County Mental Health, Chemical Abuse and Dependency Services Division to implement the Recovery and Resiliency-Oriented Behavioral Health Services Plan 2012 – 2017. The current ordinance grew out of an earlier plan and ordinance for the mental health system that was successful in transforming the mental health system to a recovery orientation. The concept of recovery in the substance use disorders treatment world has evolved and a more comprehensive behavioral health plan was in order.

## Ordinance Overview

- Updates language in the ordinance to better reflect what we know and understand about recovery from both mental illness and substance use disorders.
- Explicitly adds resiliency as a concept that applies better to children, youth, and older adults.
- Incorporates recovery from substance use disorders into a more comprehensive behavioral health system plan.
- Includes the value of trauma-informed care, as trauma is both a predictor of mental illness and substance abuse and often a result of those disorders.
- Calls for annual progress reports on the status of strategies and goals, outcomes, and performance measures.

## Plan Overview

The plan anticipates three phases of change:

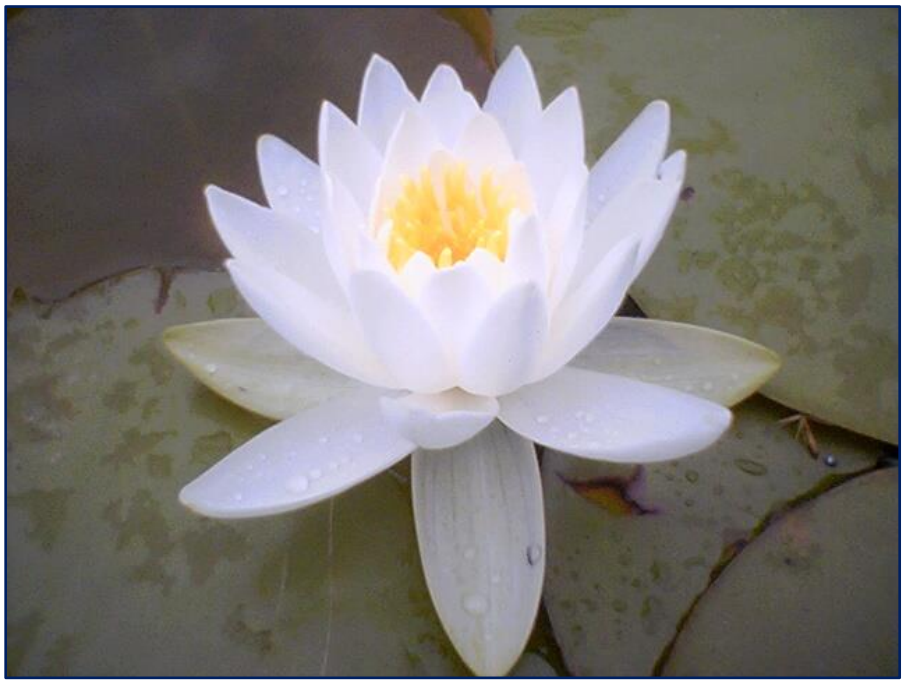
1) Creating and sustaining a shared vision
2) Implementation
3) Consolidating and deepening change.

These three phases will address the following strategies:

- Workforce training
- Creating incentives to change practices
- Supporting grassroots advocacy for change
- Addressing these changes in contracts and policies

The plan will transform the behavioral health system from one that focuses primarily on case management under a medical model that promotes only sobriety, maintenance, and stability to one that sees people as equals engaged in a "process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." This comes from the definition of recovery developed by the federal Substance Abuse and Mental Health Service Administration (SAMHSA). Building upon what is strong within people rather than focusing on what is wrong with them supports recovery.

This vision of recovery reduces stigma, increases social inclusion, improves health, and reduces costs such as hospitalization, incarceration, and healthcare. While this system transformation most directly impacts those who have mental health and substance use challenges, these changes also serve those who provide services. Ultimately, the entire community benefits from recovery.



# Recovery Month 2013

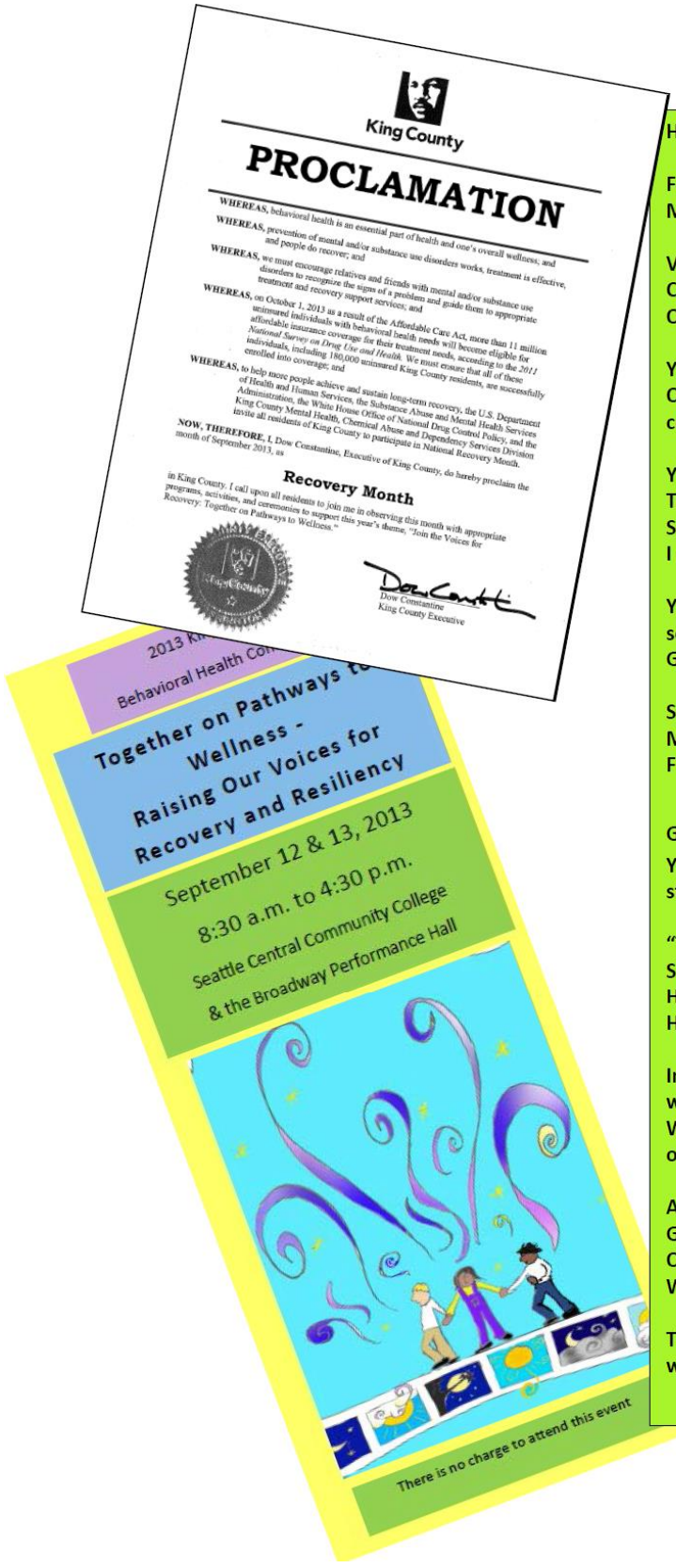
In 2013, King County had proclamations issued by mayors and other local leaders in 33 out of 39 towns and municipalities, declaring September as National Recovery Month. Several King County staff attended city council meetings throughout the County to receive the proclamations. All proclamations were posted on the King County and Substance Abuse and Mental Health Services Administration (SAMHSA) websites and displayed at the King County annual Exemplary Awards celebration. This event that recognizes outstanding contributions to recovery by community based organizations and individuals was also held in September as part of National Recovery Month.

King County held its annual Recovery and Resiliency conference, attracting more than 300 providers and community members affected by mental health and substance abuse conditions. There were 36 workshops, supplemented by keynote presentations and opportunities to interact. A recovery banner where participants could write messages of encouragement was made, and later displayed at the Exemplary Awards celebration.

Both poetry and recovery poster contests were held prior to September. Individuals in recovery submitted artwork and poetry for consideration; the winners were given gift certificates and the winning poster and poem were displayed at the Exemplary Awards celebration. We printed calendars for community agencies that included the winning poster.

We coordinated an interdisciplinary Federal Way Rotary Club panel discussion on chemical dependency that included local mental health provider CEOs and board members, King County Alcohol and Substance Abuse Administrative Board Chair, and the Federal Way Chief of Police.

We polled community providers and posted their recovery events on the King County and SAMHSA websites, and distributed links to the SAMHSA toolkit that had many ideas for community events.




**Hold My Hand, I Will Hold Your Hope**

**Feeling so alone, scared and confused**
**Mentally beaten, battered and bruised**

**Very little hope for myself did I carry**
**Changing my life**
**Opening up sounded scary**

**You said "Hold my hand, I will hold your hope;**
**On this journey to wellness, I will help you to cope"**

**You shared your personal story**
**To relate with me and bond**
**Someone else had been there**
**I could finally go on**

**Your resiliency in hard times and renewed source of power**
**Gave me more hope, hour after hour**

**So I grew day by day, my hope was renewed**
**My mental wellness and recovery**
**Flourished and grew**

**Gently, Slowly, You let go of my hand**
**You said "Hold hope for another, Help them to stand"**

**"Tell them your story**
**Share where you've been**
**Hold their hand**
**Hold hope for them"**

**In my personal journey, I've learned how it works**
**We give deeply to each other,**
**out of our struggles and hurts**

**As we gain healing through resiliency**
**Giving and receiving hope by the hour**
**On our journey to mental wellness**
**We gain a renewed source of power**

**Thank you for holding my hope,**
**when I had little of my own**

# On the Path to Opening Recovery High School Doors

During 2013, we made an amazing start toward realizing the vision of a Recovery High School in King County. The Recovery School Planning Committee (RSPC) was created and continued to grow throughout the year, adding members from partnering agencies and other interested parties. Committee members included representatives from the treatment system, the education system, the courts, and other stakeholders. The Committee's mission is to create recovery schools in King County that provide safe and supportive environments where youth and young adults in recovery can achieve their academic, career, and recovery goals, leading to successful graduation and pathways to achievement in education, work, and healthy lives.

Three team members traveled to Minnesota to visit two recovery high schools to explore the different models being used with success. We were also fortunate to have a Master of Social Work (MSW) intern from the University of Washington's School of Social Work (SSW), who also happened to be a school-based Chemical Dependency Professional (CDP), join the planning team.

With the support of Seattle Public Schools Superintendent Jose Banda, Interagency Academy (a network of alternative high schools in the Seattle School District) came onboard as a partner to both explore opening a stand-alone Recovery High School and to create a recovery component at their Columbia City Health and Wellness Academy site. Navos also came onboard as a partner to hire and supervise two CDPs, funded through Group Care Enhancement (GCE) resources, who will work within Interagency Academy. Plans are for one CDP to be based at the stand-alone recovery school slated to open in late 2014. Group Health Cooperative was selected to partner with the Interagency Academy site at Columbia City to help with health needs of the students. The RSPC continues to work with other interested school districts within King County to explore the addition of a Recovery School to their programs.

# Workforce Development and Training

MHCADSD has contracted with Oregon Health and Science University (OHSU), Northwest Addiction Technology Transfer Center (NATTC) to provide training, technical assistance and leadership services to assist King County in developing and implementing a King County Workforce Development Plan (WDP) since 2011.These WDP activities are funded by the Mental Illness and Drug Dependency (MIDD) Plan's strategy #1e – *Chemical Dependency Professional Education and Training.*

The following trainings were provided to our Chemical Dependency Professionals (CDP) in 2013. These programs provided research/evidence based Continuing Education Units (CEUs) for maintenance of licensure and enhanced CDP clinical skills:

| Training | Hours | # of times offered |
|---|---|---|
| Introduction to Motivational Interviewing | 16 | 4 |
| Advanced Motivational Interviewing | 16 | 3 |
| Motivational Interviewing Booster Session | 6 | 5 |
| Clinical Supervision 1 Workshop | 16 | 2 |
| Clinical Supervision 2 Workshop | 16 | 2 |
| Treatment Planning Workshop | 6 | 4 |
| Motivational Interviewing On Site Technical Assistance | 20 | Spread over 4 months |
| Clinical Supervision On Site Technical Assistance | 4 per agency | 4 agencies |

There were 301 participants in these trainings, which were designed to be small and emphasize skill building. An additional 6 individuals benefited from ongoing coaching in Motivational Interviewing (MI) and another 6 received ongoing Screening, Brief Intervention, and Referral to Treatment (SBIRT) training. Evaluations for these trainings have been overwhelmingly positive. Often the only criticism is that the trainings fill up too quickly and providers are forced to wait for a later training.

# Washington State Screening, Brief Intervention, and Referral to Treatment – Primary Care integration (WASBIRT – PCI)

MHCADSD is partnering with the Washington State Department of Social and Health Services (DSHS) Divisions of Behavioral Health and Recovery (DBHR) and Research and Data Analysis (RDA), and with Public Health – Seattle & King County (PHSKC) to implement year three of a five-year, $8.3 million federal SAMHSA grant that was awarded to Washington State in 2011. The funds were awarded to DBHR who subcontracted with MHCADSD to coordinate implementation in King County.

Funding is being used to support selected primary care clinics in providing SBIRT services to adults receiving primary care. The project is expected to reduce alcohol and drug consumption and its negative health impacts, increase abstinence, and reduce costly health care utilization.

During 2013, four primary care clinics continued providing annual SBIRT screening services to all adult patients seen at the clinic. Clinics included Public Health North, Downtown Public Health, SeaMar Burien, and SeaMar Seattle. A fifth clinic, SeaMar White Center, was added during 2013. The SBIRT screening process included a brief universal "pre-screen" for all adults seen at the clinic. For those who pre-screen positive, the AUDIT and/or DAST-10 (two validated questionnaires for assessing problematic alcohol or other drug use respectively) were administered as a more comprehensive screening. Based on AUDIT and DAST-10 scores, patients received brief interventions that ranged from a positive health message for those at low to no risk through a referral for more in-depth assessment and treatment for those who scored at highest risk. Due to significant rates of co-occurring substance use and mental health disorders, anyone who scored as a risky drinker/drug user or above was also screened for depression and anxiety using the validated PHQ-9 and GAD-7.

Throughout 2013, a total of 8,727 adults in King County received an SBIRT pre-screen at one of the primary care clinics listed above, a slight decrease from the 9,453 who were screened in 2012. Of those, 1,123 were identified as needing a full screen, 185 scored within the range for a brief intervention, 59 scored within the range for brief treatment, 101 scored within the range for a referral to treatment.[1] The reason for the drop in pre-screens is due to an experienced clinic rotating off of the grant, as planned, and a new clinic rotating on. New clinics take some time working out the best ways to introduce a new practice.

The project experienced many additional successes in 2013:

- MHCADSD partnered with DBHR to revise the Medicaid State Plan to include SBIRT Billing Codes and credentials to become effective January 1, 2014.
- Three statewide SBIRT trainings, including one in King County, were held to assist providers in meeting the Health Care Authority (HCA) SBIRT billing credentialing requirement.
- Two tribal statewide SBIRT trainings were held to assist providers in meeting the HCA SBIRT billing credentialing requirement.
- Progress was made toward getting the Healthy Options plans to adopt the current WASBIRT protocol and screening tools as their requirement for contracted providers.

[1] These are unduplicated counts and not everyone who pre-screened positive received a full screen. The brief intervention, brief therapy, and referral to treatment numbers are based on a subset of 1,123 patients who prescreened positive.

# Opiate Treatment Expansion

In 2013, the opiate treatment system was stretched beyond capacity, leaving many on a waiting list. Because of this demand, a growing national and local heroin epidemic, and anticipated expansion in the Medicaid-eligible population under Affordable Care Act (ACA) changes going into effect in 2014, two King County-supported opiate treatment programs took steps to meet burgeoning need.

Therapeutic Health Services (THS) opened a new clinic in Bellevue in 2013, reducing the need for Eastside residents with opiate treatment needs to travel into Seattle. Many people already in treatment were able to transfer to this new clinic site, enhancing treatment access on the Eastside.

Evergreen Treatment Services (ETS) took significant steps toward opening a new clinic in south King County, where there is also significant treatment need.

Both programs are making plans to add additional shifts at existing clinics to meet projected expanded need. Both agencies also have plans to expand access to Suboxone (Buprenorphine) treatment in the coming year.

# Integrated Dual Disorders Treatment and Re-entry Case Management – Making a Difference for Individuals Involved in the Criminal Justice System

Many individuals in the criminal justice system suffer from substance use disorders. Often they experience co-occurring mental illness. King County has been supporting evidence-based treatment programs to improve outcomes for many incarcerated individuals returning to the community.

## Impact Program

The Impact Program provided by Community Psychiatric Clinic (CPC), provides integrated co-occurring disorder outpatient treatment and transitional housing for an 18-month benefit period. The program consists of two evidence-based practices, Integrated Dual Disorders Treatment (IDDT) and Moral Reconation Therapy (MRT), to serve King County Regional Mental Health Court (RMHC) and Drug Diversion Court, and the City of Seattle Municipal Mental Health Court (MMHC). The target population consists of adults who are clinically appropriate and amenable to participate in all aspects of the program, including medication management, mental health therapy, substance abuse treatment groups, MRT, and checking in with a case manager on a frequency agreeable to the court and program.

*Mr. B, a man in his forties, was referred to the CPC Impact Program from Drug Court. He is diagnosed with bipolar disorder and alcohol, cocaine, and amphetamine dependence. Mr. B had owned his own business and was doing well, but his involvement with drugs, alcohol, and unaddressed mental health problems eventually resulted in him losing his business and straining many relationships.*

*Mr. B had a dozen jail bookings and a DUI conviction by the time he entered the 18-month Impact Program. He was psychiatrically hospitalized a few years ago; upon discharge, he resumed his drug and alcohol use and did not follow up with recommended community mental health services. While incarcerated in 2011, Mr. B was placed on medication for his bipolar disorder, but failed to take his medication upon release and became homeless. Upon entry into the Impact Program, he was provided clean and sober housing. Soon thereafter, Mr. B was placed on appropriate medication that he continues to take regularly, which, along with individual and group counseling, has stabilized his mental health condition.*

*Right away, Mr. B was as an engaged client who was not only committed to his own recovery, but also willing to reach out to help others. He would frequently provide other clients with support during court appearances and housing and 12-step meetings. Mr. B enjoyed accompanying new Impact clients to housing and helping them adjust, providing peer support.*

*The opportunity to simultaneously address his substance abuse and mental health problems in an integrated manner has been the key to Mr. B's success. He recently moved to permanent housing and has mended family relationships, along with creating new supportive relationships in the clean and sober community. Mr. B has plans to start another business when the time is right, and his peers and program staff have no doubt of his ability to be successful.*

## Project START

Project START began in late August 2003 and was named by a client to emphasize the beginnings of the recovery process. The acronym for "Sober Transitions and Recovery Today" became the moniker to describe the philosophy of harm reduction in a mental health and chemical dependency framework. Project START offers integrated outpatient treatment to adults with co-occurring mental health and chemical dependency disorders. Treatment includes group, individual, and peer support and is supplemented with 24-hour crisis intervention, housing support, payee services, and other assistance.

Project START is currently based at the Sound Mental Health (SMH)-Tukwila site, specifically to address the needs of clients referred directly from the Maleng Regional Justice Center (MRJC) and municipal jails located in south and east King County. Project START has incorporated the evidence-based practice known as Integrated Dual Disorders Treatment (IDDT) in their program since 2011. Low-income King County residents who have had multiple recent incarcerations may be referred by release planners or criminal justice liaisons assigned to the MRJC or the five municipal jails in King County including Enumclaw, Issaquah, Kent, Kirkland, and the South Correctional Entity (SCORE, which is located in Des Moines and serves the cities of Auburn, Burien, Des Moines, Federal Way, Renton, SeaTac, and Tukwila).

*Ms. W is a 45-year old woman with two minor children and one adult child. She lost a baby in 2012. She was admitted to Project START at the beginning of 2013. Her mother has been supportive of her through her addiction and is currently taking care of Ms. W's children while she concentrates on her recovery. She doesn't know her father or his side of the family.*

*Ms. W has an extensive criminal history with charges of theft, assault, domestic violence, and malicious mischief. She started smoking cigarettes at age 13, abusing alcohol at age 16, and smoking crack cocaine in her late teens. By the age of 40, Ms. W was injecting heroin. She stated that she had been the victim of domestic violence in multiple relationships she had while abusing substances.*

*Ms. W presented with severe grief and loss issues, especially regarding her deceased son. While working with START she was able to process the grief/loss, eventually accepting that the father of the child has no remorse. Ms. W stated, "I am seeking treatment because I'm tired of getting high. I'm tired of going to jail. I'm tired of not having my family around me. I'm just tired." She said that she never felt loved or accepted. Ms. W reported that she has depression, stating, "I have a bad temper and anxiety." She also presented with suicide ideation, insomnia, nightmares, and obesity.*

*Ms. W's attendance in treatment is excellent. She has been a role model for her peers, has successfully completed Intensive Outpatient substance use disorder treatment and Seeking Safety (trauma-informed care), and is currently attending Goal Achieving and Roadmap to Success groups in preparation to return to school. Ms. W has transitioned from living in a clean/sober house to living in her own studio apartment subsidized by Sound Mental Health. This has allowed her to work on rebuilding her relationship with her children, having them over on weekends and holidays. Ms. W has resumed being active with her children's school activities and their personal development.*

*She continues to work towards accomplishing her treatment goals that include obtaining full-time employment in the coming months. Ms. W has had no relapses since being admitted to START and is slated to complete the program in late 2014.*

## Re-entry Case Management Services

The Re-entry Case Management Services (RCMS) are case management services that encompass the various elements of re-entry for an individual returning to the community from incarceration or being discharged from a Community Correction Division program. Services include assessment, development of coordinated plans to transition to the community, linkage to community-based mental health and substance abuse treatment, and other support services for up to 90 days post release. Services are available to low-income King County residents with mental health/substance abuse disorders who are being released from a designated facility.

*Mr. Z was referred to the Re-entry Case Management Services (RCMS) program while he was incarcerated at the City of Kent Corrections Facility. He was assessed and seen several times while in jail. He presented with anxiety, depression, and amphetamine and alcohol dependence and was alienated from community supports.*

*Upon release from custody, he was provided with clothing and personal hygiene items and transported by RCMS staff to the SeaMar Behavioral Health Residential Treatment Center. The RCMS case managers saw Mr. Z three times while in the treatment facility to help him plan successfully for his return to the community. Upon discharge, he was transported to his probation officer in Kent, where he was reluctant to check-in. Mr. Z 's case manager used Motivational Interviewing and strength-based approaches to persuade him to keep his probation appointment, and assisted in making the meeting more productive.*

*The RCMS case manager provided phone support to Mr. Z to facilitate his engagement in mental health counseling and linked him to medical services in his community. The RCMS case manager also successfully helped him find housing in downtown Seattle. "I feel great having my own place," Mr. Z said.*

*He was linked to outpatient substance use disorder treatment and the RCMS case manager provided him with ideas for positive recreational pursuits. Mr. Z expressed an interest in vocational training and was subsequently linked to the FareStart vocational training program.*

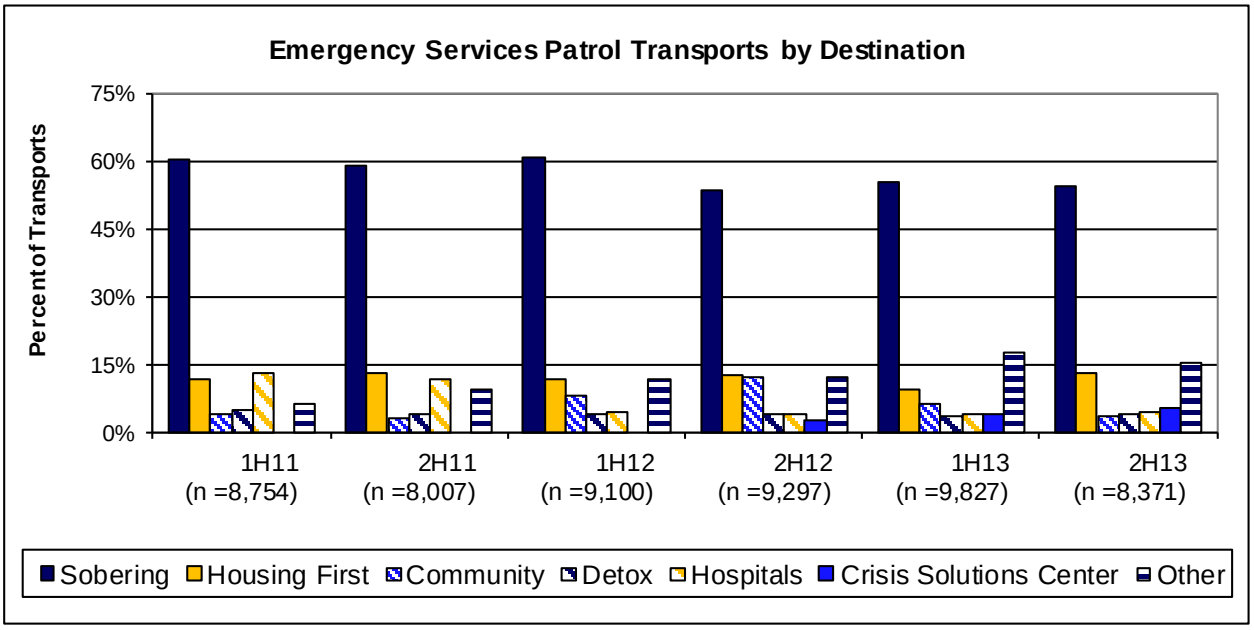
*Mr. Z has continued to attend outpatient treatment groups and take his medication. He is busking (street performing) with his guitar, and reports continued ongoing sobriety. Mr. Z is experiencing a reduction in anxiety and an increase in healthy, prosocial interactions.*

# Substance Use Disorder Intervention Programs

Preventing and treating drug abuse and dependency, commonly referred to as substance use disorders, is consistent with the King County Strategic Plan health and human potential goal of providing opportunities for all communities and individuals to realize their full potential, and fulfills all the strategic plan objectives allied with this goal. It should be noted that data reported here include only data on publicly funded programs managed by the County, and do not include privately funded services, physician office based Suboxone treatment, or residential treatment programs.

# Emergency Services Patrol

The main duty of the Emergency Services Patrol (ESP) screeners is to relieve firefighters, police, and medics from caring for chronic users in need of non-emergency assistance. They do this primarily by transporting individuals to the Dutch Shisler Service Center (DSSC), commonly known as the Sobering Center, or to other safe environments. The screeners also patrol the downtown core, seeking out individuals in need of service. In addition, they transport clients from the sobering service center to other providers. The service operates 24 hours a day, 7 days a week, every day of the year. The chart below shows the number of individuals transported and the destination of each transport by biennial quarter.

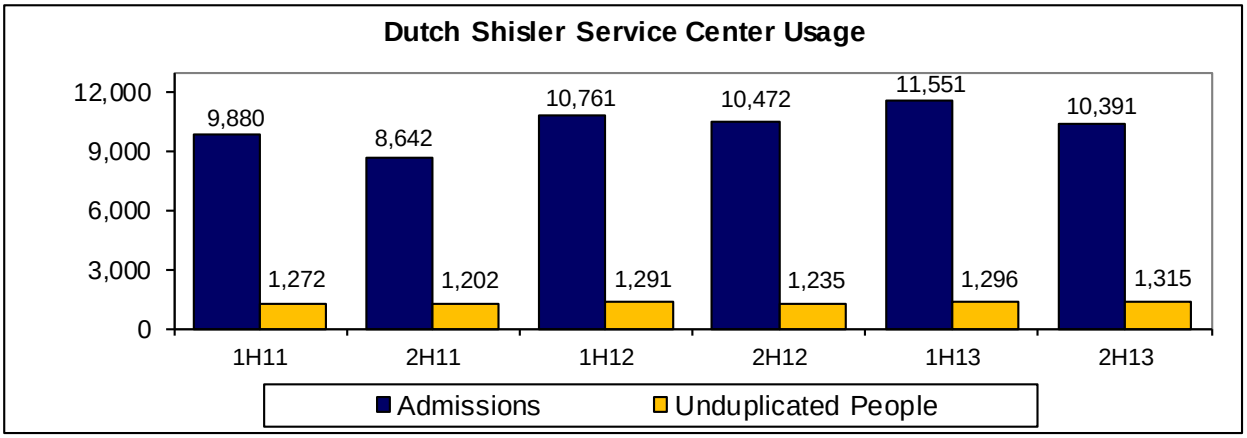



This report shows the first full year of the new transport category for the Crisis Solutions Center (CSC), which opened in mid-2012. CSC provides crisis diversion services as a therapeutic, community-based alternative to jail and hospital settings for individuals in behavioral health crisis. Upon request by CSC staff, individuals in crisis who have been referred by first responders and accepted for admission may be transported there by the ESP. This frees up first responders for other emergencies and allows trained personnel to work with people's behavioral health needs appropriately. Client-specific demographic data about ESP services are not currently available. Until those data are available, the demographic data from DSSC provide a good approximation of ESP client demographics as a majority of transports are to that site.

# Dutch Shisler Service Center

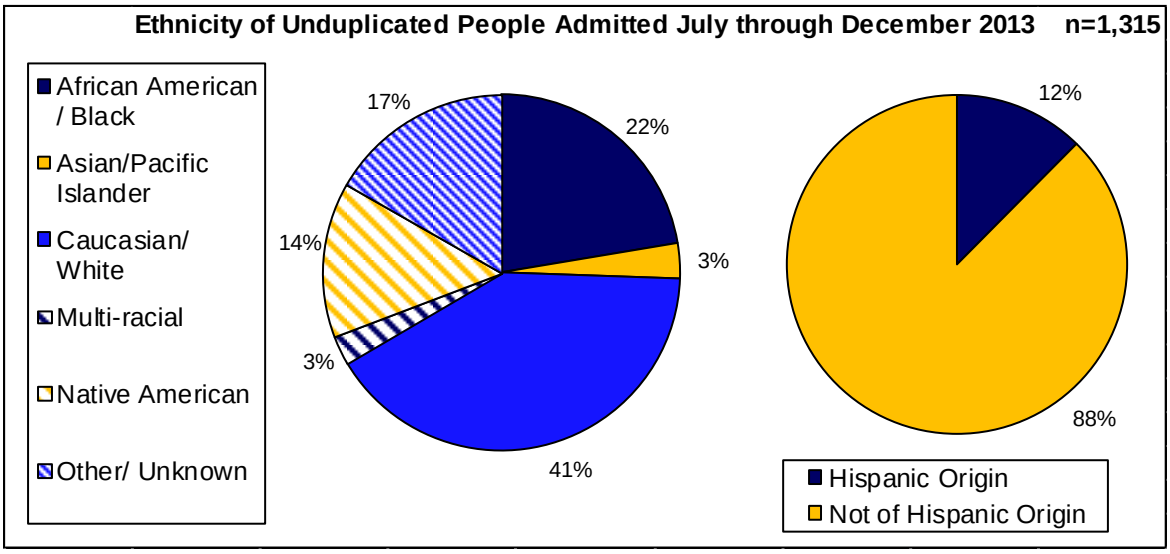
The Dutch Shisler Service Center (DSSC) serves as a safe and secure place for persons to sleep off the acute effects of intoxication and is an important recovery entry point in King County's recovery-oriented system of care. It serves as a center for clients to access case management services, outpatient chemical dependency treatment, and other assistance to move towards greater self-sufficiency.

The chart below shows the number of admissions to the Dutch Shisler Service Center for sobering services, and the number of unduplicated people who used that service.

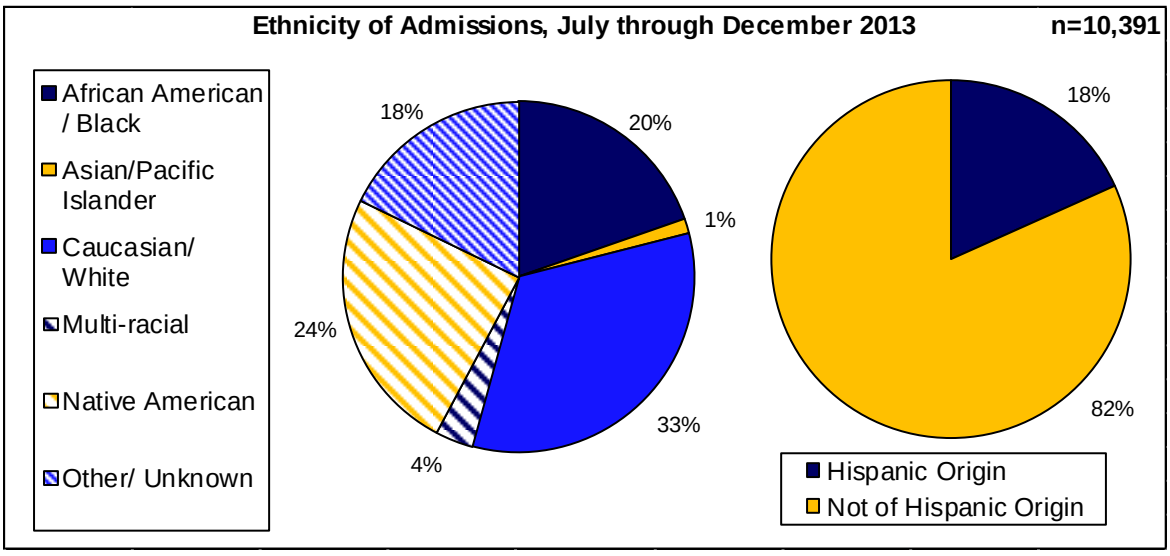



From the data above, it is clear that some individuals have multiple admissions to DSSC. In the last biennial quarter, 8.4 percent (110) of the 1,315 people admitted accounted for 60 percent of the total admissions. These 110 individuals averaged 57 admissions each during the six-month period, with a range from 25 to 160 admissions. Frequent users of the center are often involved in multiple systems, such as primary and behavioral health, social services, criminal justice, and housing. These individuals have complex and chronic needs and are generally not served effectively by the high-cost settings, such as emergency departments, they tend to access.

The following charts show the ethnicity of unduplicated people served by DSSC from July through December 2013. See Appendix A for additional details.



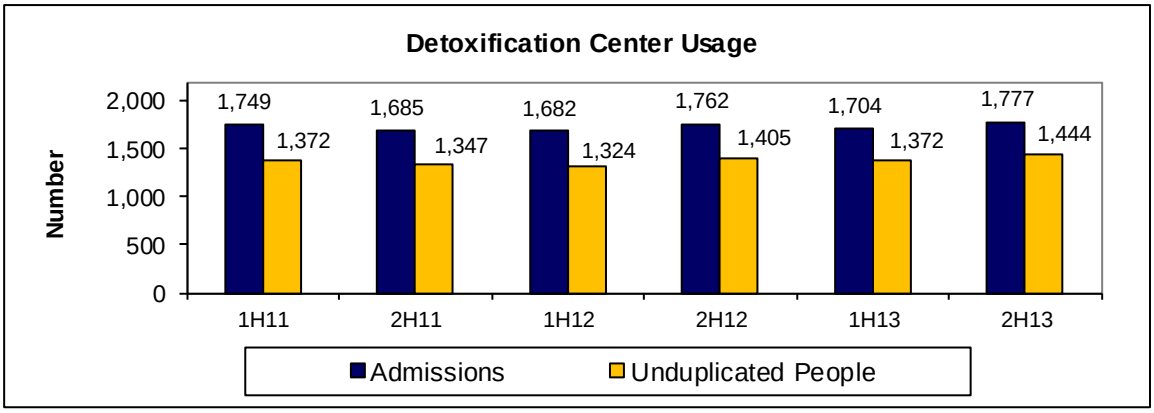

Among those admitted to DSSC during July through December 2013, the percentage who are Native American (14 percent) is much higher than the percentage of Native Americans in either the general population (two percent) or in any other drug/alcohol program area except Involuntary Commitment Services (see Summary Data, Demographic Detail). In addition, a disproportionate number of the frequent users of DSSC are Native American: 21 percent of those admitted five times or more in the last biennial quarter were Native American. As shown in the chart on the left below, 24 percent of all admissions to DSSC in the last biennial quarter are for Native Americans although Native Americans are only 14 percent of the unduplicated individuals served, as shown in the chart on the left above. Disproportionate frequent use of the center by Native Americans is a continuing trend (data not shown.)



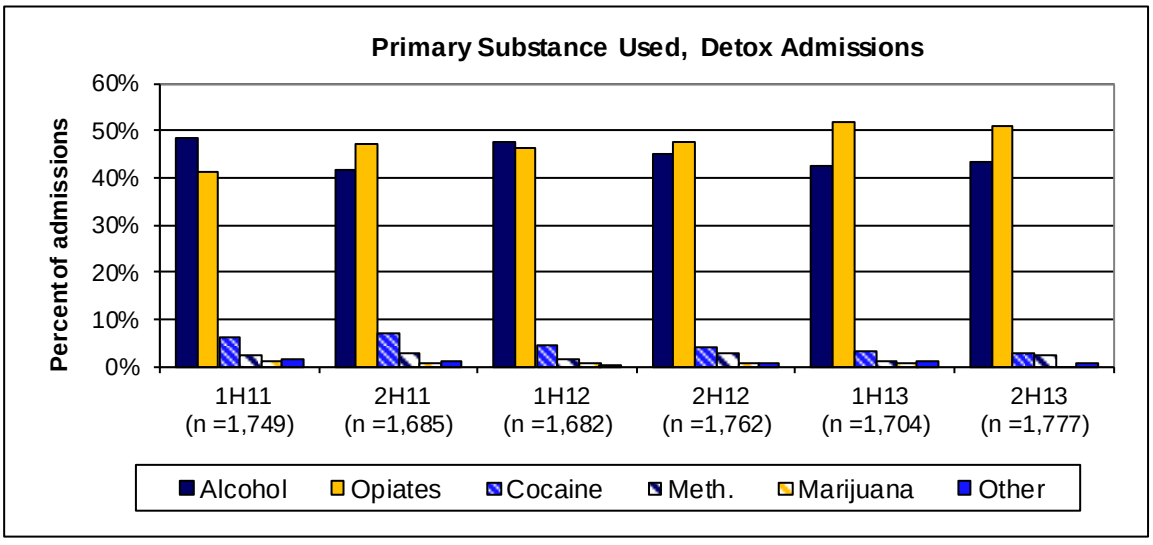
# Detoxification Center

Detoxification services are provided to indigent clients who are withdrawing from alcohol or other drugs. Upon successful completion of detoxification services, clients are referred for ongoing treatment and support.

The chart below shows the number of new admissions to the Detoxification Center during each biennial quarter and the number of unduplicated people admitted.



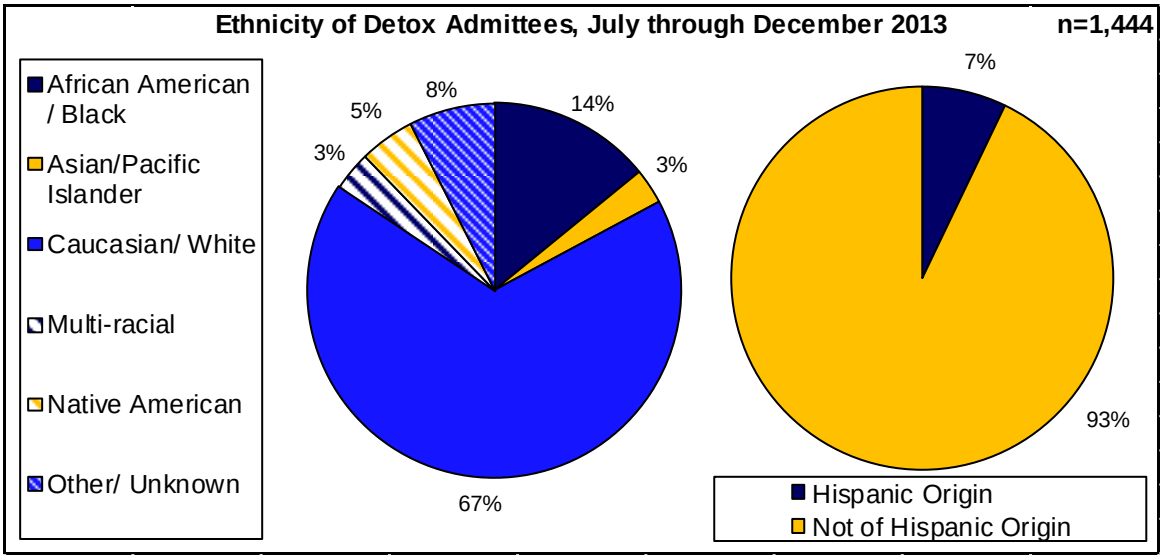

The following chart shows the primary substance used by people admitted to the Detoxification Center. This is usually, but not always, the substance for which detoxification is needed (see Appendix A for more information).




There was a steady increase over the six biennial quarters from 2009 (not shown) through 2011 in the percentage of detoxification clients who indicate opiates as their primary drug used. That increase leveled off in 2012, but resumed in 2013. Alcohol went from being the primary substance used for 62 percent of admissions in the first half of 2009 to only 43 percent of admissions in the second half of 2013. The second biennial quarter of 2011 was the first time that opiates surpassed alcohol as the primary drug reported upon admission to detoxification services. This trend in admission data is consistent with epidemiological trends statewide and nationally, showing a rise in opiate use.

From the first half of 2008 through the second half of 2011, there was a steady increase in the number and percentage of young adults under 30 years old entering detoxification services. After leveling off in 2012, the number and percentage of young adults increased again. Among all individuals admitted in 2013, *85 percent of those under 30 years old indicated opiates are their primary drug used* compared to 36 percent of those 30 years or older. See the "Program Comparisons" section for more discussion of these changes.

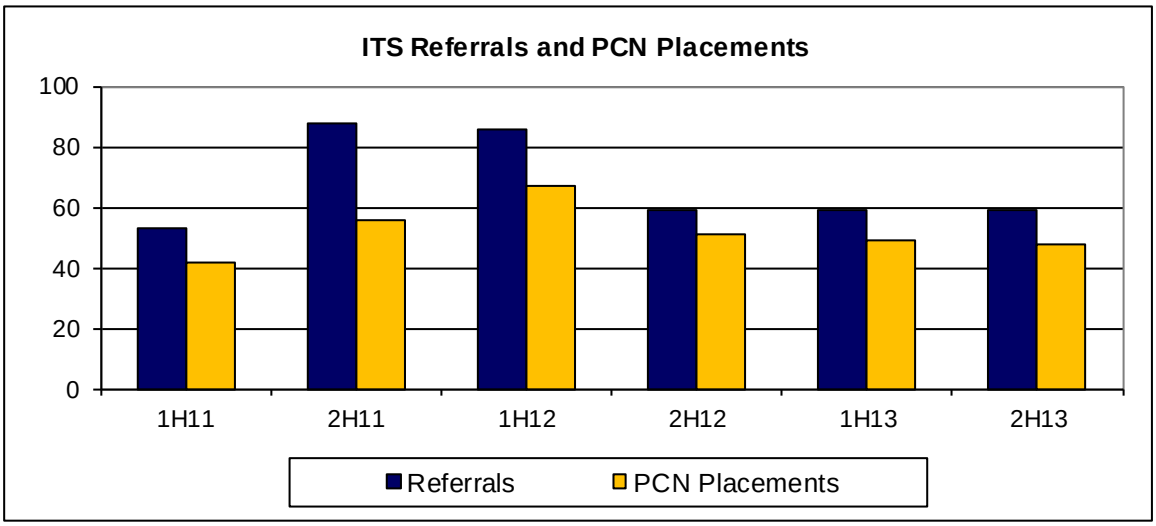
The charts below show the ethnicity of unduplicated people admitted to the Detoxification Center from July through December 2013. See Appendix A for additional details.



# Involuntary Commitment Services

Involuntary Commitment Services (ICS) include investigation and evaluation of facts to determine whether a person is incapacitated as a result of substance use. If a substance use disorder specialist determines there is reliable evidence to support a finding of incapacity, a petition for commitment can be filed on behalf of the incapacitated person. Courts can then authorize a person to a locked treatment facility for intensive treatment.

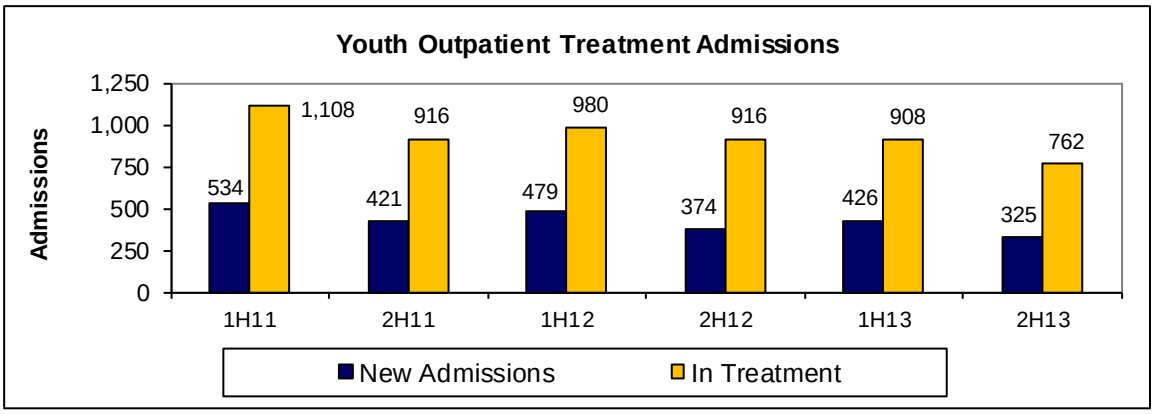
The following chart shows the referrals received by ICS for investigation and the number of commitments that resulted in a placement at Pioneer Center North (PCN) for inpatient treatment.



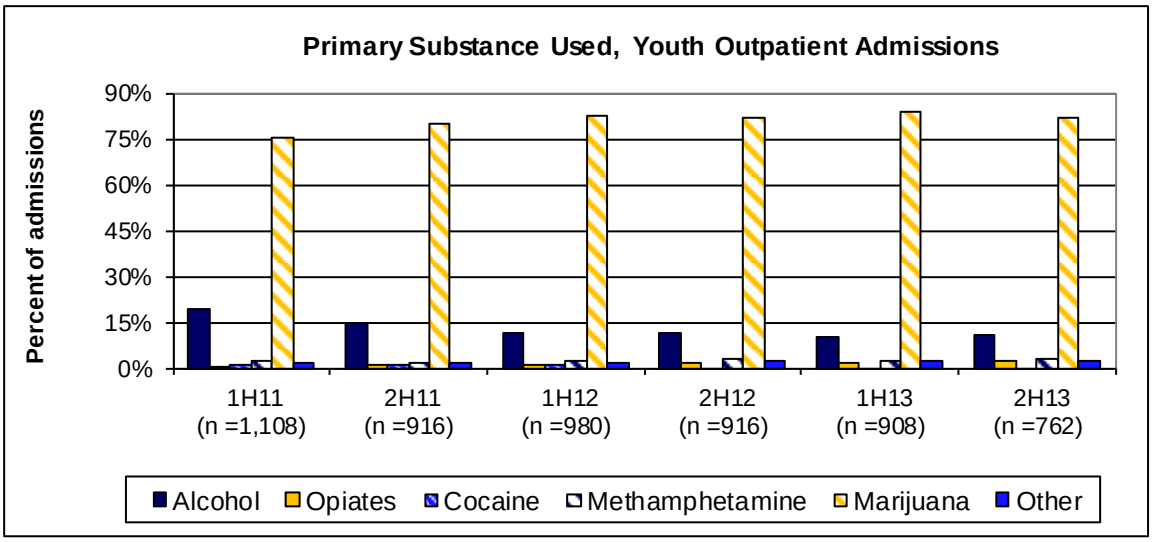
# Outpatient Treatment – Youth

Outpatient treatment services for youth are targeted for low-income and indigent youth who are abusing or who are dependent on alcohol and/or other substances. Services include development of sobriety maintenance skills, family therapy or support, case management, and relapse prevention. Services are expected to improve school performance and peer/family relationships, prevent or reduce criminal justice involvement, and to decrease risk factors associated with substance use and abuse.

The following chart shows existing caseloads plus new admissions to outpatient treatment for youth under 18 years old. Both "new admissions," which started during the biennial quarter, and "in treatment" are shown. "In treatment" includes anyone who was admitted at any time and not yet discharged by the start of the quarter.

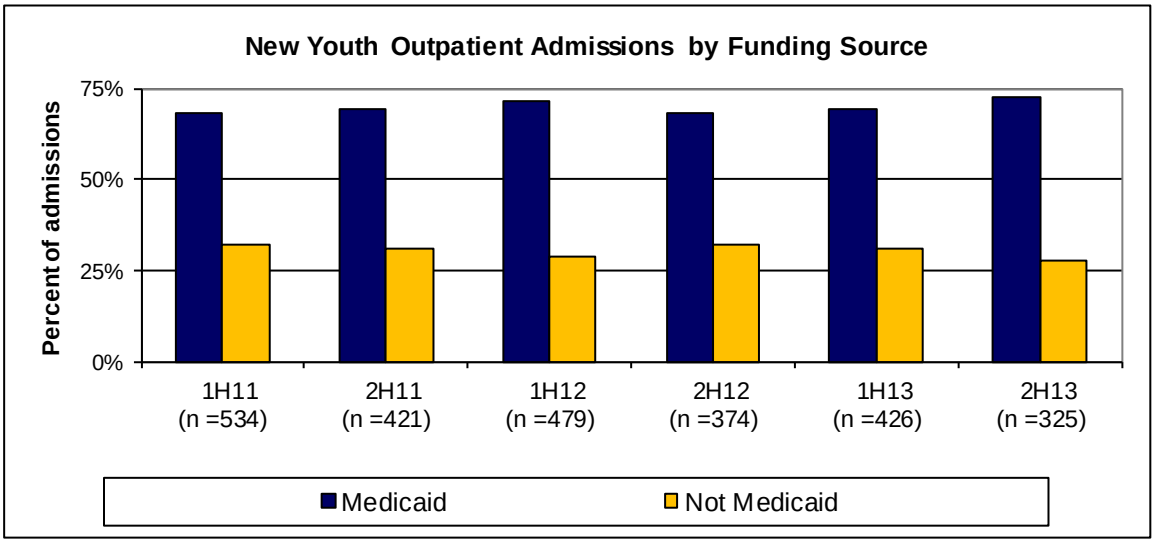



The following chart shows the primary substance used by youth in outpatient treatment.

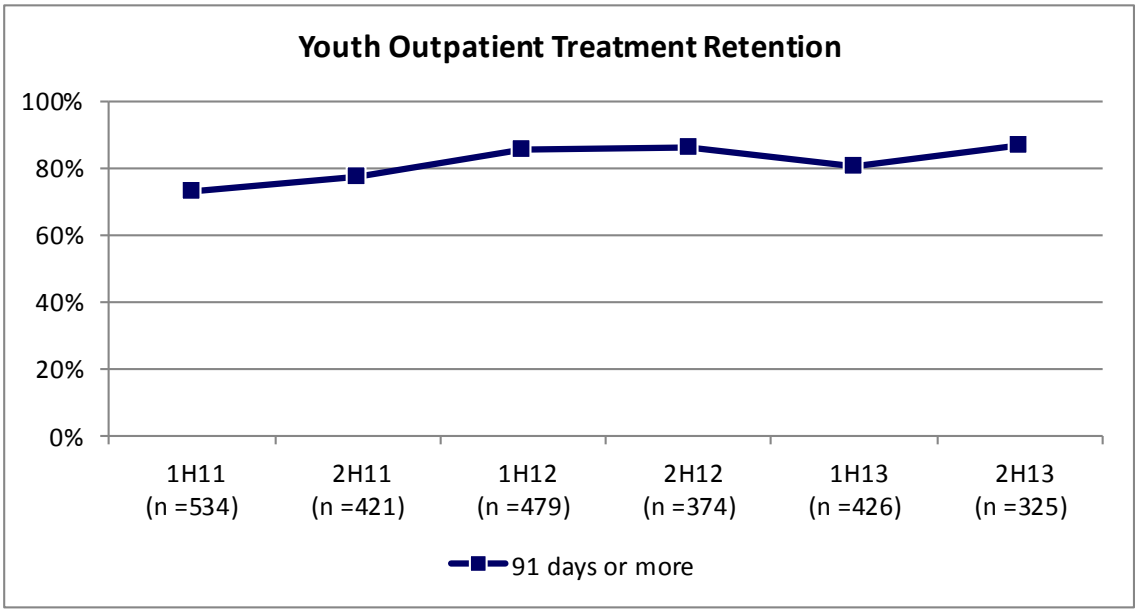



While the most frequently used drug among youth in treatment is marijuana, a significant percentage of youth are using alcohol. The difference in proportion for those admitted to treatment for marijuana versus alcohol continues to grow, with marijuana increasing and alcohol decreasing as the primary substance used. A very small but increasing number of youth are in treatment for opiate use, which appears to become more problematic for people in their twenties. In addition, opiate use is often treated via other modalities, such as medication-assisted treatment or detoxification. The chart below

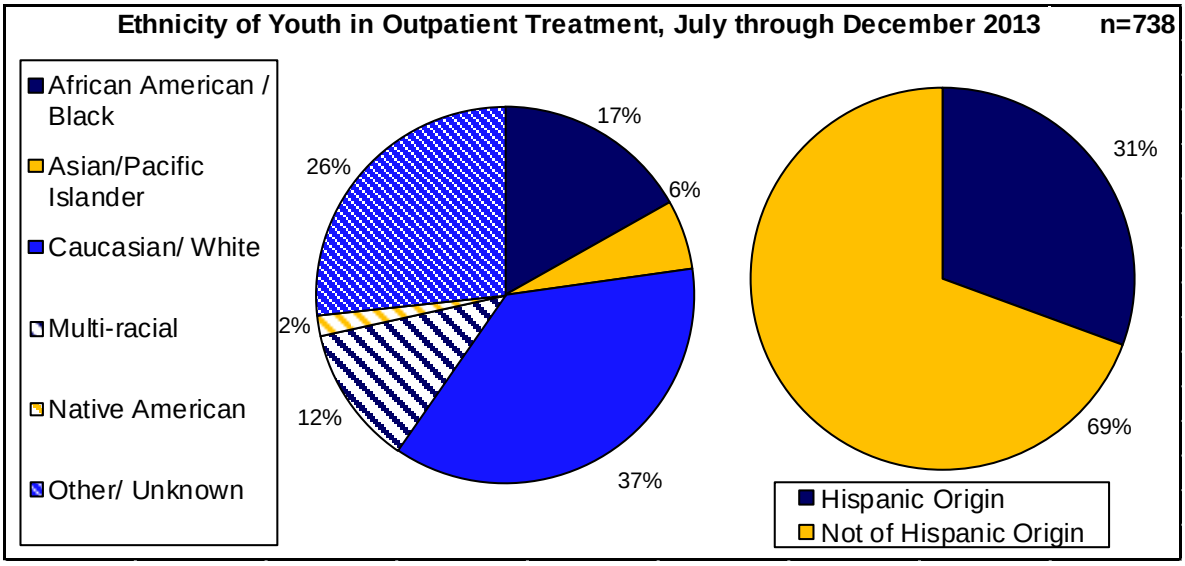
shows the proportion of newly admitted youth each biennial quarter whose treatment is funded by Medicaid versus other public funding.




In mid-2011, the Washington State Division of Behavioral Health and Recovery (DBHR) dropped a long-standing focus on treatment completion as a key outcome measure and shifted focus to treatment retention starting in 2012. Because research shows that people who remain in treatment for more than 90 days tend to have better outcomes, this report now includes a measure of those who started treatment during each report period and remained in treatment for 91 days or longer. (See Appendix A for details on how the rate is determined.)



The charts below show the ethnicity of unduplicated youth receiving outpatient treatment from July through December 2013. (See Appendix A for additional details.)

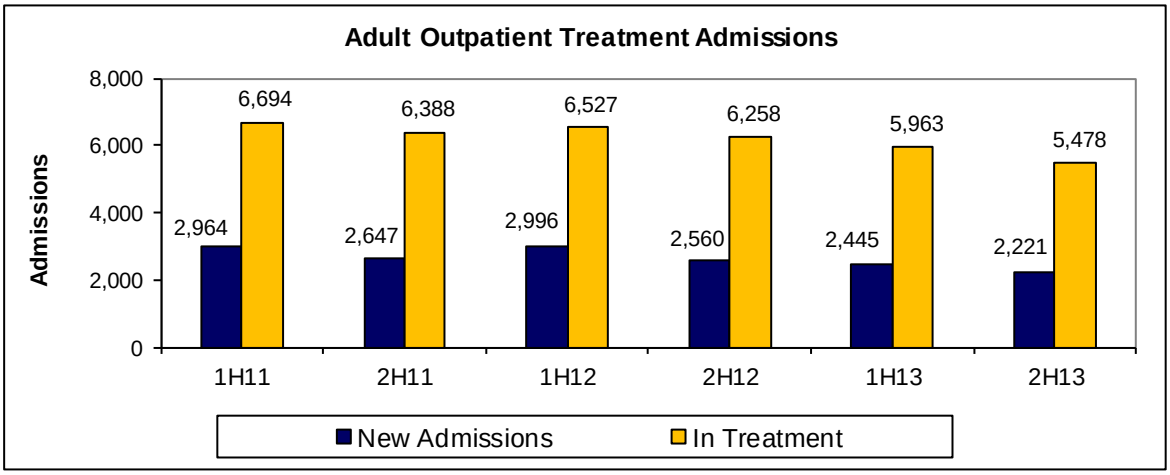



The vast majority of those who report other/unknown are of Hispanic origin. Among all youth who reported a single ethnic group that was Other (or unknown), about 85 percent also reported some Hispanic origin. About 75 percent of youth who reported some Hispanic origin also reported a single ethnic group of Other (or unknown).

# Outpatient Treatment – Adult

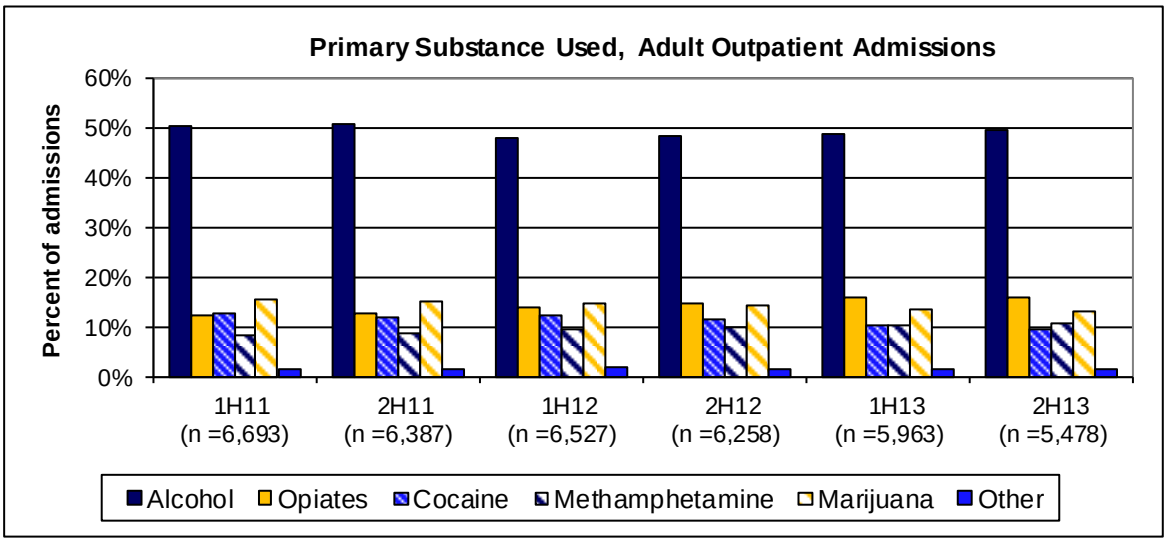
Outpatient treatment services are provided to low-income and indigent adults, 18 years and older, who need treatment to recover from addiction to drugs and/or alcohol. Services are designed to assist clients with achieving and maintaining sobriety and achieving other recovery goals in their lives, and can include individual face-to-face treatment sessions, group treatment, case management, employment support, or other services, including referrals to appropriate agencies.

The following chart shows caseloads and admissions to outpatient treatment for adults, 18 years and older. Both "new admissions," which started during the biennial quarter, and "in treatment" are shown. "In treatment" includes anyone who was admitted at any time and not yet discharged by the start of the quarter.



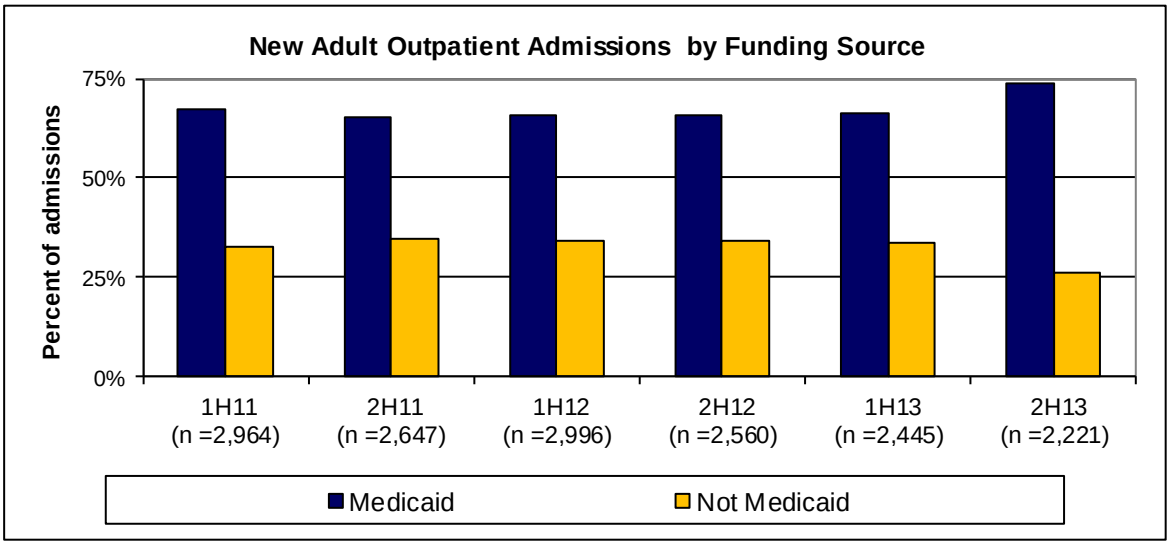

The decreases from 2011 through 2013 in the number of people remaining in treatment reflect decreased state funding available for outpatient treatment for those who do not have Medicaid coverage.

The following chart shows the primary substance used by adults in outpatient treatment.



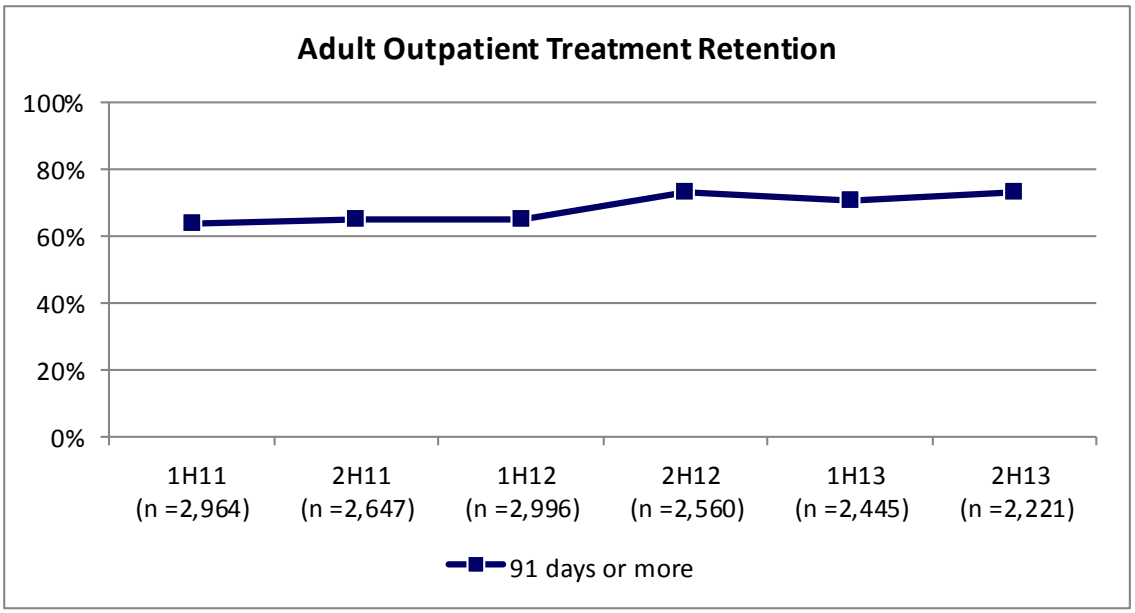
Although the total number of adults in treatment decreased 12 percent between 2011 and 2013, the number in treatment where the primary substance used was opiates increased by 13 percent. Across the quarters in this report, there was a fairly steady increase in the percentage reporting opiates as the primary substance, from 12 percent in the first quarter of 2011 to 16 percent in the second quarter of 2013. Alcohol remained by far the most frequently reported primary substance used.

The following chart shows the proportion of newly admitted adults each biennial quarter whose treatment is funded by Medicaid versus other public funding.



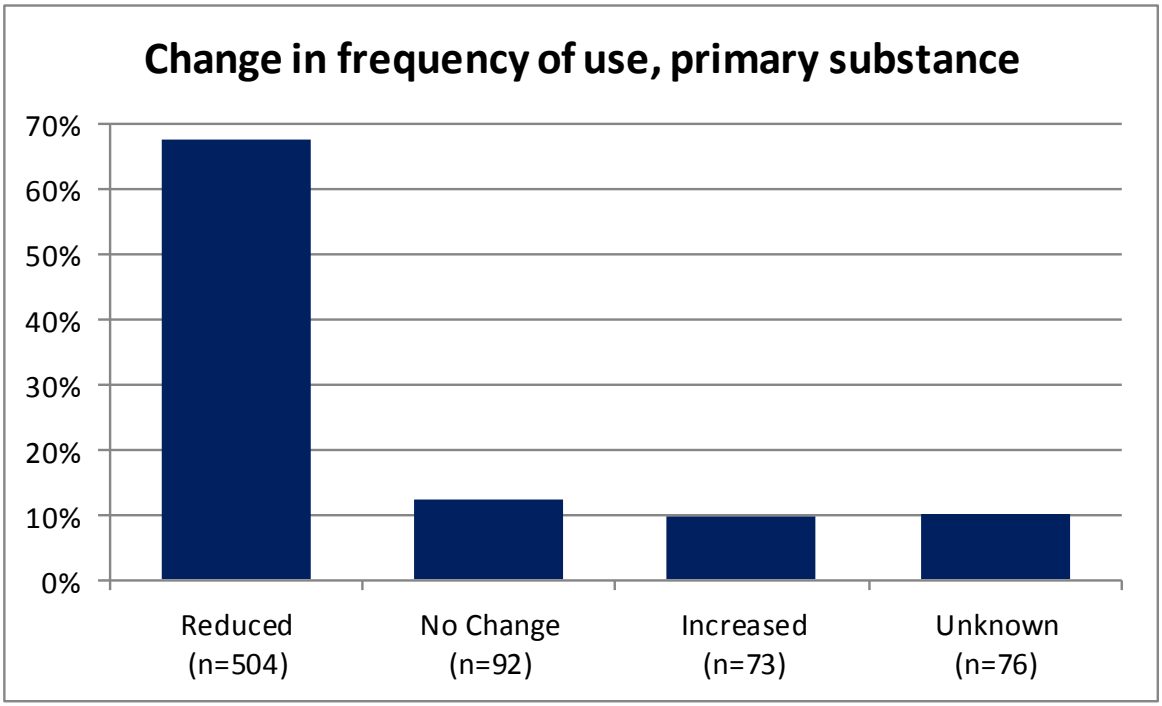

The shift in proportion of Medicaid funded admissions from 66 percent in the first half of 2013 to 74 percent in the second half of 2013 is a function of decreased state resources for individuals who are not eligible for Medicaid. Absolute numbers of Medicaid admissions remained constant, while there was an overall 9 percent decrease in total admissions during this same period. The Affordable Care Act (ACA), which expands Medicaid coverage to many low-income adults starting in 2014, is expected to increase both the number and percentage of adults with Medicaid who start outpatient treatment during 2014.

In mid-2011, DBHR dropped a long-standing focus on treatment completion as a key outcome measure and shifted focus to treatment retention. Because research shows that people who remain in treatment for more than 90 days tend to have better outcomes, this report now includes a measure of those who started treatment during each report period and remained in treatment for 91 days or longer. (See Appendix A for details on how the rate is determined.)

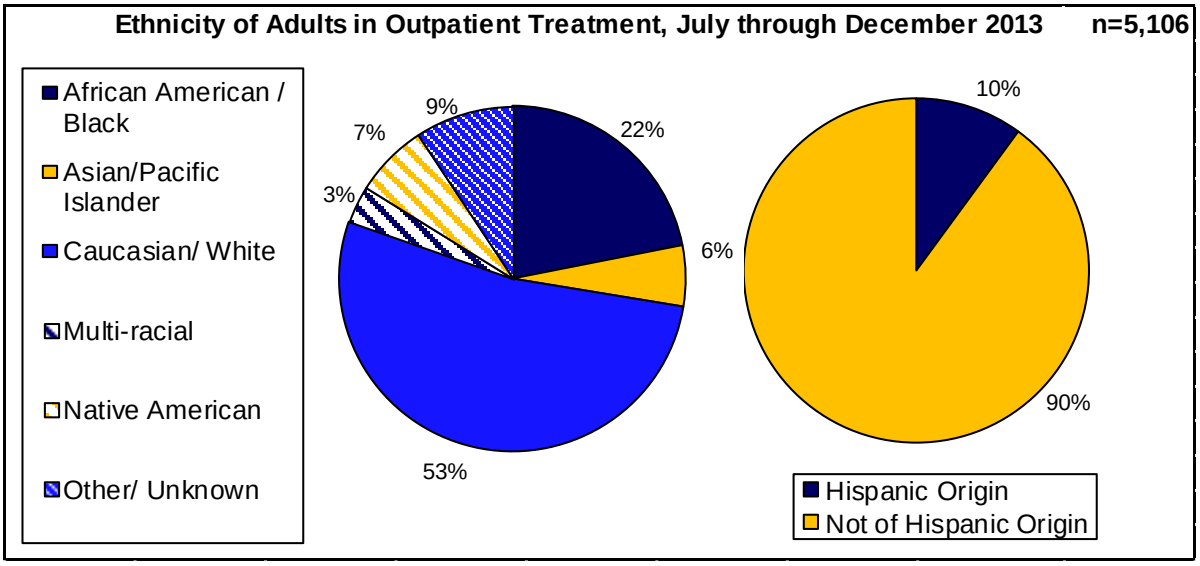



Since July 2011, King County providers of adult outpatient treatment have been reporting data about important recovery indicators for people who have been in treatment more than six months. For 2013, the new data are sufficiently complete to begin using. One of these indicators is how frequently the person used their primary substance in the 30 days before the reporting date.

The following chart shows the reported change in use from admission to the last data reported for 2013. Because many people start outpatient treatment with a provider immediately after outpatient treatment with a different provider, residential treatment, or incarceration, a large proportion had no use in the 30 days before admission. Those admissions are excluded from the data shown below to better reflect the impact of treatment on substance use.



The charts below show the ethnicity of unduplicated adults receiving outpatient treatment from July through December 2013. See Appendix A for additional details.

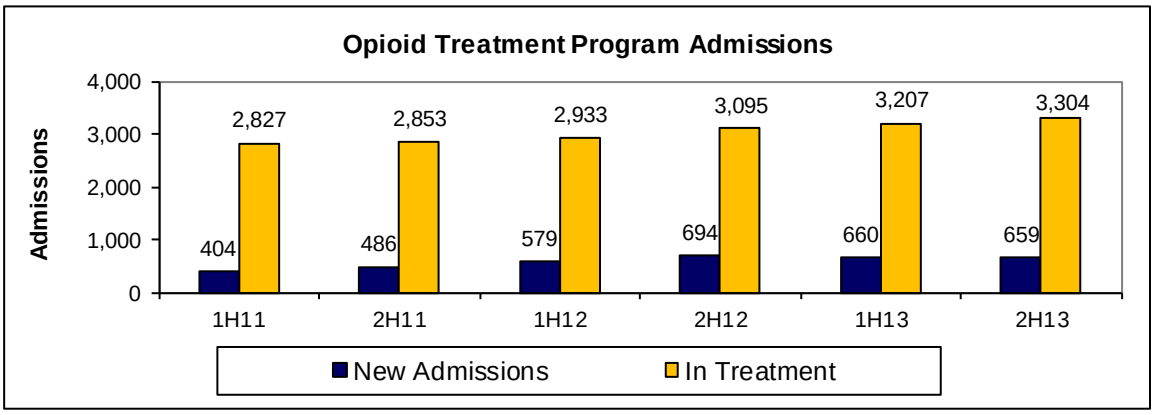



The majority of individuals who report Other/Unknown race report being of Hispanic ethnicity. Among all adults who reported a single ethnic group that was Other (or unknown), about 75 percent also reported some Hispanic origin. About 60 percent of adults who reported some Hispanic origin also reported a single ethnic group of Other (or unknown).

# Opioid Treatment Programs

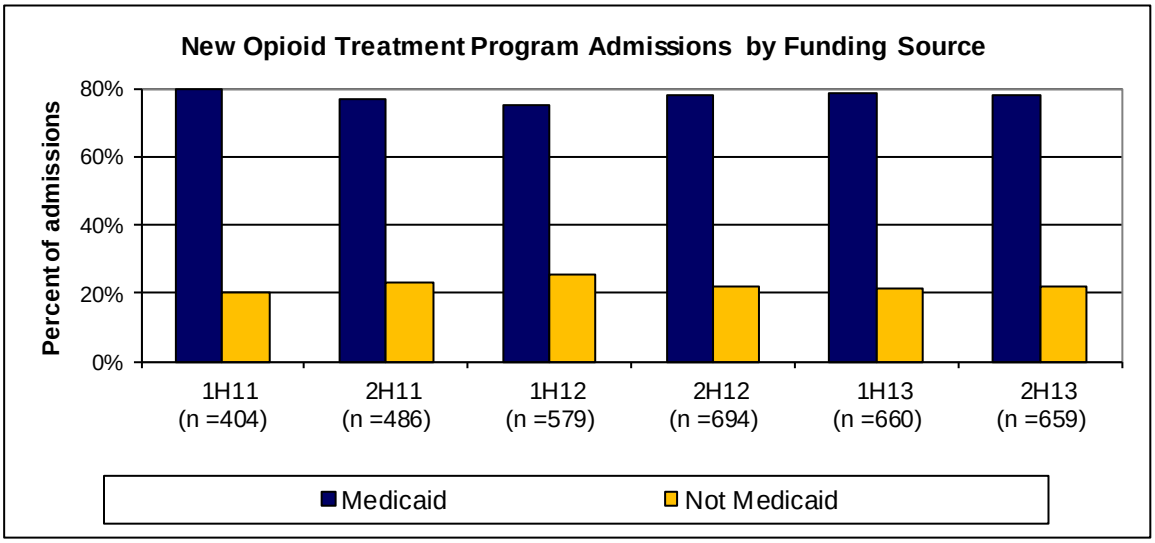
Opioid treatment programs (OTP) provide medically supervised medication-assisted treatment services to individuals addicted to opiates, whether to heroin or prescription opiates. In addition to physical exams and medical monitoring, clinics provide individual and group counseling, medications, urinalysis screening, referral to other health and social services, and patient monitoring.

The chart below shows caseloads and admissions to opioid treatment programs. Both "new admissions," which started during the biennial quarter, and "in treatment" are shown. "In treatment" includes anyone who was admitted at any time and not yet discharged by the start of the quarter.



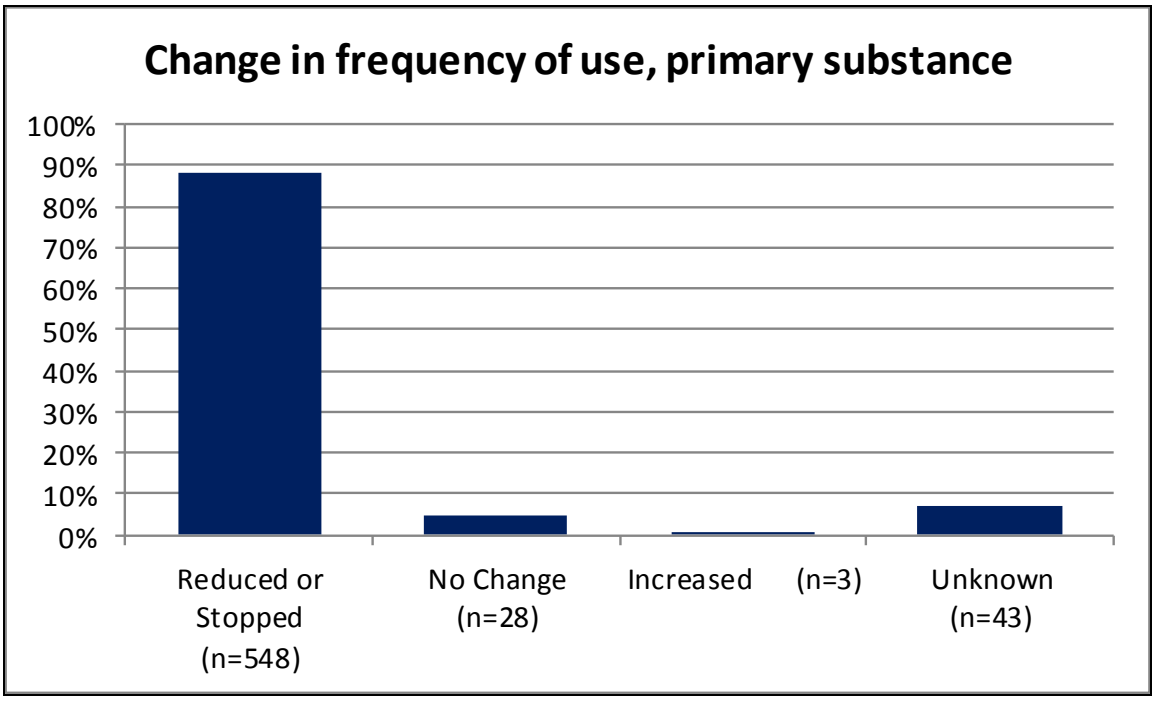

Consistent with the goals of this treatment modality, individuals tend to be retained in medication-assisted treatment for long durations, limiting the availability of new treatment slots. The increase in both new admissions and people in treatment that started during the second half of 2012 reflects increased treatment capacity from the new OTP clinic that opened in Bellevue in July 2012. This new capacity resulted in a 37 percent increase in the average number of admissions per biennial quarter when the three biennial quarters after the new clinic opened are compared to the three quarters before July 2012. Because many of those newly served have remained in treatment, the number of people receiving treatment during the second half of 2013 increased 16 percent from the second half of 2011. The County is working with treatment providers to open another new clinic in south King County to continue to address limited capacity and countywide services (see King County Opiate Treatment Expansion, p. 15). Trends in treatment admissions have historically been a function of funding availability and service capacity. Demand has exceeded both funding and service resources for years, and individuals needing treatment have been kept on a waiting list. The waiting list had been hovering in the low 300's prior to the opening of the new clinic.

The following chart shows the proportion of newly admitted people each biennial quarter whose opioid treatment is funded by Medicaid versus other public funding.

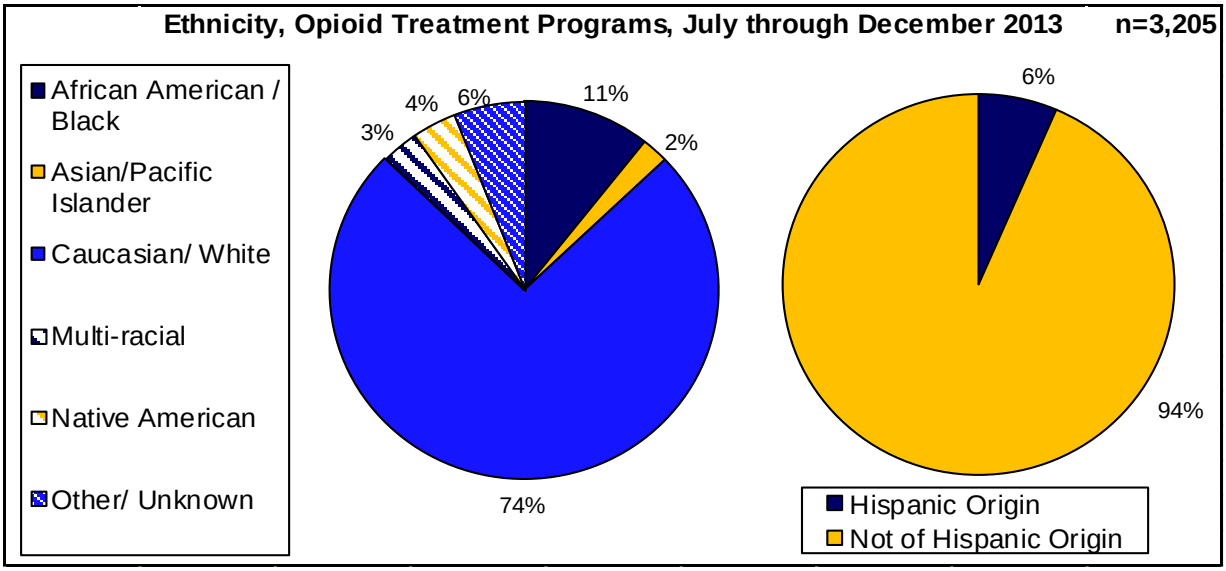



Since July 2011, King County OTP providers have been reporting data about important recovery indicators for people who have been in treatment more than six months. For 2013, the new data are sufficiently complete to begin using. One of these indicators is how frequently the person used their primary substance in the 30 days before the reporting date.

Data are required for people who started an opiate treatment program with a provider on or after 2011, and remained in treatment with the provider for at least six months. The following chart shows the reported change in use from the beginning of an episode to the last data reported for 2013. Episodes where the person had not used the primary substance for which treatment was needed, but may have used another substance, are excluded from the data shown below in order to better reflect the impact of treatment on the use of the primary substance.



The following charts show unduplicated people receiving opioid treatment from July through December 2013. See Appendix A for additional details.




Among all who reported a single ethnic group that was Other (or unknown), about 60 percent also reported some Hispanic origin. About 45 percent of those who reported some Hispanic origin also reported a single ethnic group of Other (or unknown).

# Summary Data

## Overview

This section provides summary data from the last calendar year on services provided, dispositions, and demographics of individuals served. It also provides summary data for the last three calendar years for financial revenues and expenditures.

The services data are for the same program areas and measures that were presented graphically in the Programs section. The time period that the data describe is different. Data in this section are for the most recent calendar year, which is the same time period as the last two biennial quarters shown in the charts. See Appendix A for additional details.

The demographic data are broader than the data in the Programs section. The gender, race or ethnic group, and Hispanic origin status of all unduplicated individuals served during the most recent calendar year are reported. This includes all programs except the Emergency Services Patrol.

To provide context, U.S. Census Bureau data for gender and ethnicity in the youth and adult populations in King County that are below the federal poverty level are shown in addition to the demographic data for each program. Although many people with somewhat higher incomes also qualify for public funding, these data approximate the gender and ethnic mixtures among King County residents who are eligible for publicly funded services. Data for the "Youth Outpatient" programs should be compared to the "Youth" population. All other programs except Prevention serve only adults. (Data Source: U.S. Census Bureau, 2005-2009, American Community Survey, B17001A-I tables.)

The financial data (see page 40) include a financial plan for actuals for 2011, 2012 and 2013, and the expenditures for outpatient treatment services. The financial plan shows the beginning fund balance, revenues received by revenue type, expenditures made by expenditure, and the ending fund balance. The financial plan does not include dollars from the Mental Illness and Drug Dependency (MIDD) Action Plan. The chart at the bottom of the page combines the contracted expenditures for outpatient treatment services from the financial plan with the MIDD expenditures. The chart is broken out by outpatient treatment services for adults and youth, and opioid treatment programs. Total contracted outpatient services accounted for $16,707,296 in 2011, $17,734,478 in 2012, and $17,830,881 in 2013.

Title XIX (Medicaid) dollars are not included in the financial plan figures. Title XIX dollars combine state and federal funds to pay for treatment services. Money is set aside from the MHCADSD biennium contract with the State and allocated to chemical dependency treatment agencies to provide treatment services. These dollars are then matched with federal dollars and disbursed by the state directly to agencies for treatment services provided to Medicaid recipients. For 2013, the Title XIX County Billing Detail Reports provided by DBHR and agency reports as recorded in the MHCADSD Invoice Processing System show that $10,093,261 was billed by agencies with $9,223,203 paid to agencies. This is a decrease from the amount paid to agencies in 2012 of $214,713 or 2.3 percent.

# Services and Dispositions, January – December 2013

| | Number | Percent |
|---|---|---|
| **ESP Transports** | | |
| All Destinations | 18,198 | 100% |
| Sobering | 9,995 | 55% |
| Housing First | 2,005 | 11% |
| Street | 884 | 5% |
| Detox | 714 | 4% |
| Hospitals | 763 | 4% |
| Crisis Solutions Center | 837 | 5% |
| Other | 3,000 | 16% |
| **Sobering Center** | | |
| Admissions | 21,941 | |
| Unduplicated People | 2,122 | |
| **Detoxification Center** | | |
| Admissions | 3,481 | |
| Unduplicated People | 2,517 | |
| Admissions by drug of choice | 3,481 | 100% |
| Alcohol | 1,489 | 43% |
| Opiates | 1,789 | 51% |
| Cocaine | 106 | 3% |
| Methamphetamines | 61 | 2% |
| Marijuana | 12 | 0% |
| Other | 24 | 1% |
| Referrals on discharge, all d/c | 3,470 | 100% |
| Self-help | 9 | 0% |
| CD TX | 3,155 | 91% |
| Other | 3 | 0% |
| ADATSA | 256 | 7% |
| ICS | 46 | 1% |
| Housing | 1 | 0% |
| **Involuntary Commitment Services** | | |
| Referrals | 118 | |
| Unduplicated people | 111 | |
| PCN Placements | 97 | |

| | Number | Percent |
|---|---|---|
| **Outpatient Treatment** | | |
| **Youth** | | |
| New admissions | 751 | |
| In Treatment | 1,233 | |
| Unduplicated people (open) | 1,151 | |
| Open admissions by drug of choice | | |
| Alcohol | 137 | 11% |
| Opiates | 17 | 1% |
| Cocaine | 1 | 0% |
| Methamphetamines | 34 | 3% |
| Marijuana | 1,018 | 83% |
| Other | 26 | 2% |
| New admissions by Medicaid status | | |
| Medicaid | 529 | 70% |
| Not Medicaid | 222 | 30% |
| Treatment retention for admissions during year | | |
| 91 days or more | 623 | 83% |
| Less than 91 days | 128 | 17% |
| **Adult** | | |
| New admissions | 4,666 | |
| In Treatment | 8,184 | |
| Unduplicated people (open) | 7,243 | |
| Open admissions by drug of choice | | |
| Alcohol | 3,939 | 48% |
| Opiates | 1,326 | 16% |
| Cocaine | 801 | 10% |
| Methamphetamines | 887 | 11% |
| Marijuana | 1,113 | 14% |
| Other | 118 | 1% |
| New admissions by Medicaid status | | |
| Medicaid | 3,253 | 70% |
| Not Medicaid | 1,413 | 30% |
| Treatment retention for admissions during year | | |
| 91 days or more | 3,348 | 72% |
| Less than 91 days | 1,318 | 28% |
| **Opioid Treatment Programs** | | |
| New admissions | 1,319 | |
| In Treatment | 3,866 | |
| Unduplicated people (open) | 3,571 | |
| New admissions by Medicaid status | | |
| Medicaid | 1,033 | 78% |
| Not Medicaid | 286 | 22% |

## Program Comparisons

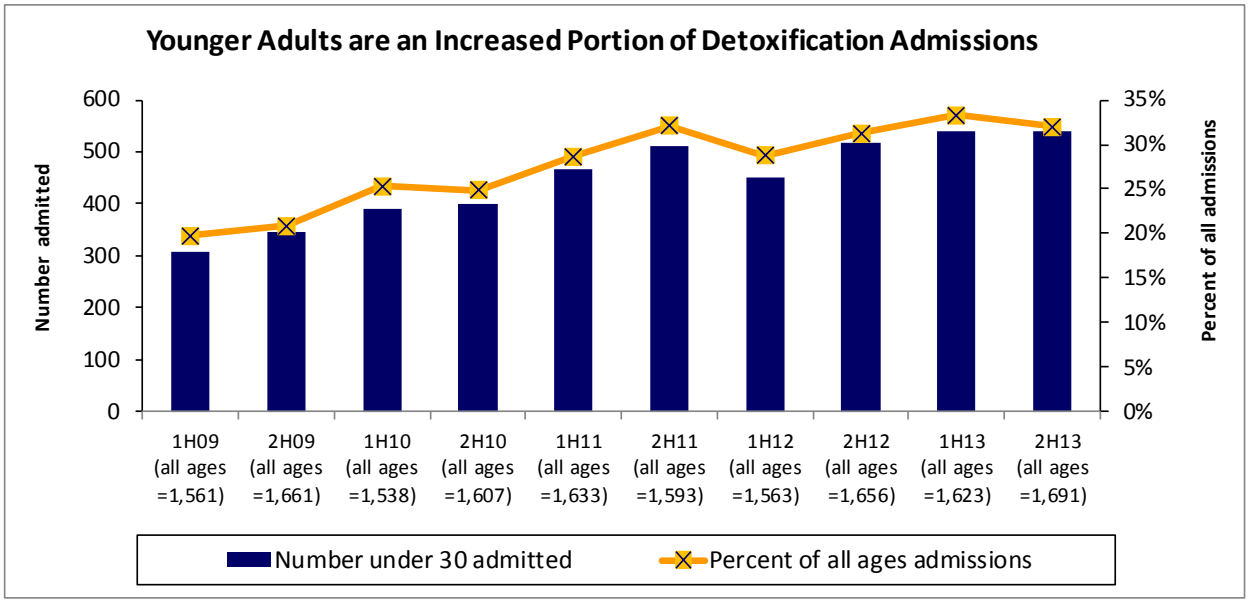
The table below shows data for the primary substance used by people admitted to different program areas and highlights differences among substances used.

**Comparison of Primary Substance Used, January - December 2013**

| | Detoxification Center Admissions* | Outpatient Youth Admissions | Outpatient Adult Admissions |
|---|---|---|---|
| **Total Number** | 3,481 | 1,233 | 8,184 |
| **Drug of Choice Percentage** | | | |
| **Alcohol** | 43% | 11% | 48% |
| **Opiates** | 51% | 1% | 16% |
| **Cocaine** | 3% | 0% | 10% |
| **Methamphetamines** | 2% | 3% | 11% |
| **Marijuana** | 0% | 83% | 14% |
| **Other** | 1% | 2% | 1% |

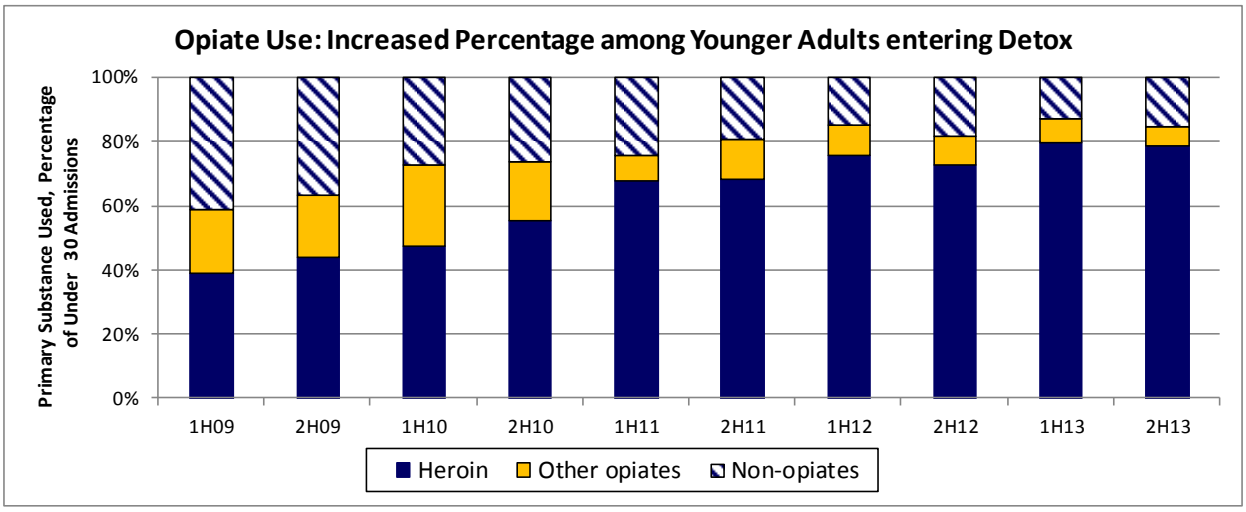
There is a dramatic difference between the Youth and Adult Outpatient identification of marijuana as the primary substance used.

As noted earlier, the percentage of people admitted for detoxification whose primary substance used is an opiate increased from 2009 through 2011 before leveling off in 2012, and the percentage using alcohol declined from 2009 through 2011. The change from 2009 through 2011 was driven by two factors shown in the following charts that also did not increase in 2012: an increase in the number and percentage of young adults under 30 years old entering detoxification services, and higher percentages of heroin or other opiate use among these detoxing young adults.

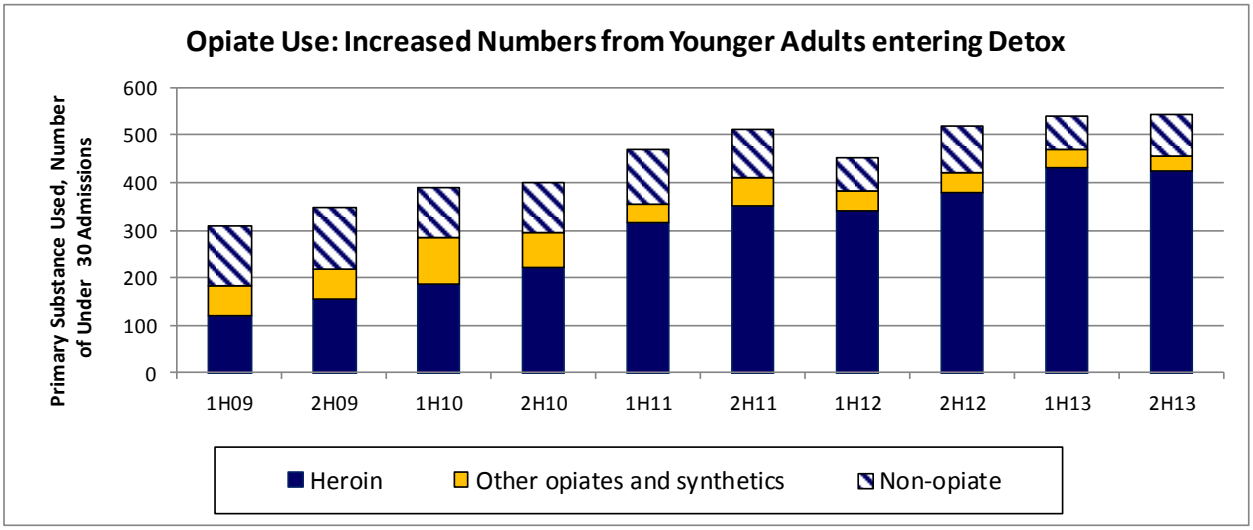



Because the total number of detoxification admissions each biennial quarter stays fairly constant, the number and percentage of young adults above had very similar increases across the five years from 2009 through 2013.

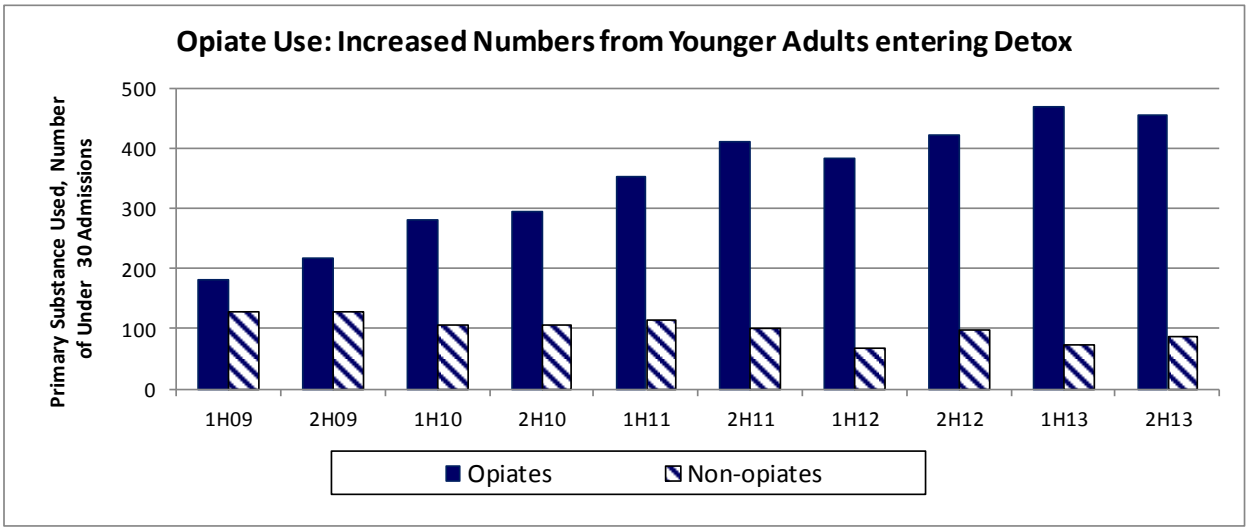
The following chart shows that, within the increased number of young adults seeking detoxification, a larger percentage is using opiates, with a more recent rise in heroin versus prescription opiates.




The following chart illustrates the compounded impact on the number of detoxification clients using opiates that has resulted from the increased percentage of younger adults in detoxification (first chart above) who are also more likely to use opiates (second chart above).



Here is another way to look at the impact of all opiate use by younger adults on detoxification admissions.




Although not as striking as the changes seen above in the use of opiates by those starting detoxification, there has been a small, continuing increase over this three year report period in the use of opiates by adults in outpatient treatment (see the Adult Outpatient Treatment section). There has not been a clear increase in younger adults entering opioid treatment programs despite the significant increase in detoxing younger adults and opiate use within that group: the percentage of those less than 30 years old who were admitted to an OTP in the last five years has varied between 24 and 29 percent with no sustained trend. It may be that some of these younger adults are accessing doctor's office-based treatment using buprenorphine and/or naltrexone or that some are opting to attempt traditional outpatient "drug-free" treatment rather than medication-assisted treatment.

The opiate use data above are consistent with the "Seattle-King County Drug Trends 2013" report from the University of Washington, Alcohol and Drug Institute, which indicates that non-heroin/non-morphine opiates have been the leading cause of drug-related death in King County since 2005. The most recent data show a rise in heroin use and a dip in prescription opiate use.

# Demographic Detail, January – December 2013

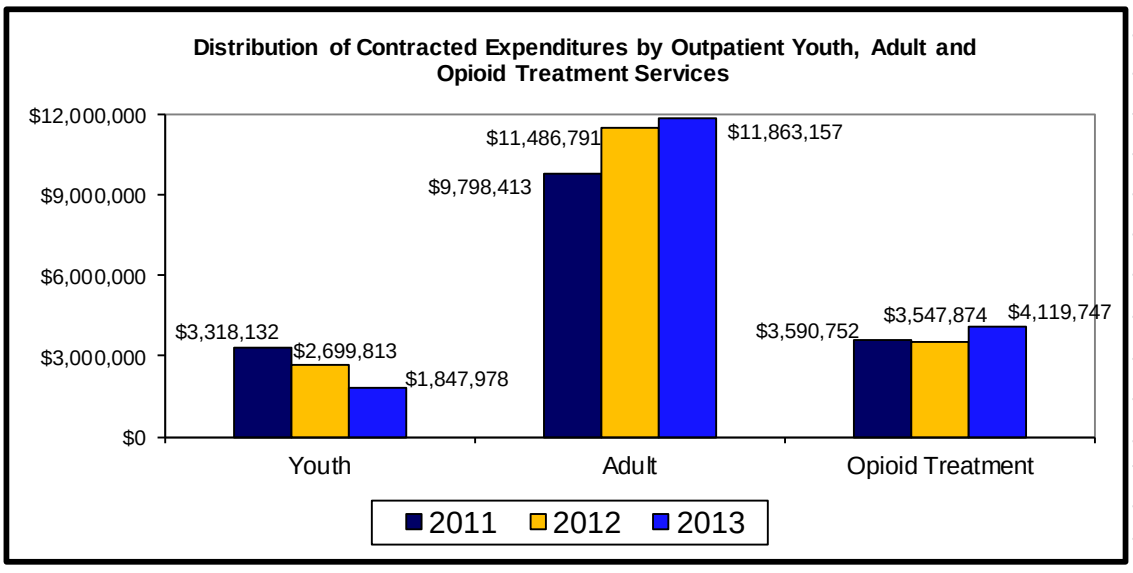
| | | | | Outpatient | | | King County Residents Below Fed. Pov. Level | |
|---|---|---|---|---|---|---|---|---|
| | Sobering | Detox | ICS | Youth | Adult | Opioid Tx. | Youth (12 - 17) | Adult (over 17) |
| **Unduplicated people served** | 2,122 | 2,517 | 111 | 1,151 | 7,243 | 3,571 | 15,709 | 154,299 |
| Gender | | | | | | | | |
| Number of people | | | | | | | | |
| Male | 1,811 | 1,714 | 101 | 817 | 4,814 | 1,883 | 7,613 | 69,148 |
| Female | 291 | 803 | 10 | 334 | 2,429 | 1,688 | 8,096 | 85,151 |
| Percent of all served | | | | | | | | |
| Male | 85% | 68% | 91% | 71% | 66% | 53% | 48% | 45% |
| Female | 14% | 32% | 9% | 29% | 34% | 47% | 52% | 55% |
| ("Unknown gender" counts are not included) | | | | | | | | |
| Race/ethnic group: | | | | | | | | |
| Number of people | | | | | | | | |
| African American | 477 | 380 | 21 | 207 | 1,609 | 377 | 2,666 | 19,124 |
| Asian/Pacific Islander | 65 | 61 | | 70 | 396 | 80 | 2,834 | 26,913 |
| Caucasian/ White | 905 | 1,703 | 61 | 415 | 3,814 | 2,658 | 7,117 | 91,605 |
| Multi-racial | 53 | 86 | | 133 | 248 | 114 | 1,350 | 6,705 |
| Native American | 275 | 108 | 17 | 24 | 494 | 129 | 182 | 2,354 |
| Other/ Unknown | 347 | 179 | | 302 | 682 | 213 | 1,560 | 7,598 |
| Percent of all served | | | | | | | | |
| African American | 22% | 15% | 19% | 18% | 22% | 11% | 17% | 12% |
| Asian/Pacific Islander | 3% | 2% | | 6% | 5% | 2% | 18% | 17% |
| Caucasian/ White | 43% | 68% | 55% | 36% | 53% | 74% | 45% | 59% |
| Multi-racial | 2% | 3% | | 12% | 3% | 3% | 9% | 4% |
| Native American | 13% | 4% | 15% | 2% | 7% | 4% | 1% | 2% |
| Other/ Unknown | 16% | 7% | | 26% | 9% | 6% | 10% | 5% |
| | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Hispanic origin: | | | | | | | | |
| Number of people | | | | | | | | |
| Hispanic origin | 250 | 171 | 6 | 347 | 712 | 236 | 4,415 | 21,870 |
| Not Hispanic origin/Unknov | 1,872 | 2,346 | 105 | 804 | 6,531 | 3,335 | 11,294 | 132,429 |
| Percent of all served | | | | | | | | |
| Hispanic origin | 12% | 7% | 5% | 30% | 10% | 7% | 28% | 14% |
| Not Hispanic origin/Unknov | 88% | 93% | 95% | 70% | 90% | 93% | 72% | 86% |
| | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

**(Percentages may not add up to 100% because of rounding. Numbers below five are removed to protect confidentiality.)**

## Financial Summary

# King County Substance Abuse Fund
# 2011 - 2013 Actuals
# Financial Plan

| | 2011 Actual | 2012 Actual | 2013 Actual |
|---|---|---|---|
| **Beginning Fund Balance** | **3,641,370** | **3,901,637** | **4,234,975** |
| **Revenues** | | | |
| Licenses & Permits | 0 | 0 | 0 |
| Federal Grants | 6,597,503 | 2,583,140 | 7,001,280 |
| State Grants | 10,533,485 | 14,403,240 | 9,793,576 |
| Intergovernment Payment | 1,155,511 | 1,179,444 | 1,120,959 |
| Charges for Services | 663,226 | 597,692 | 506,711 |
| Miscellaneous | 70,477 | 21,157 | 13,512 |
| Other Financing Sources | 0 | | |
| Current Expense | 0 | | |
| **Total Revenues** | **19,020,202** | **18,784,673** | **18,436,039** |
| **Expenditures** | | | |
| Administration | (1,859,830) | (1,789,867) | (1,944,478) |
| Housing Voucher Program * | 0 | 0 | 0 |
| Treatment | (16,000,065) | (15,982,895) | (15,208,711) |
| Prevention Activities | (900,041) | (678,573) | (1,208,044) |
| **Total Expenditures** | **(18,759,935)** | **(18,451,335)** | **(18,361,233)** |
| **Other Fund Transactions** | | | |
| Adjustment Prior Yr Expenditures | | | 1531.42 |
| DCFM Energy Surcharge Refund | | | |
| **Total Other Fund Transactions** | | | **1,531** |
| **Ending Fund Balance** | **3,901,637** | **4,234,975** | **4,311,312** |



# Appendices

# Appendix A. Data Sources

This appendix describes the data sources used for the Substance Abuse Prevention and Treatment Annual Report and issues around the quality, meaning, and availability of the data. It also includes specific notes about the data presented for different program areas.

## Data Sources

The data included in this report come from three broad types of sources:

- Summary data furnished by service providers. Such data are used for Emergency Services Patrol.
- A database developed by MHCADSD that is used by the Dutch Shisler Service Center and Involuntary Commitment Services to collect data for those programs.
- The State TARGET database that contains data from contracted providers about individuals and their treatment services. TARGET data are used for the Detoxification Center and Youth, Adult and Opioid Treatment Program outpatient treatment portions of this report. (Although the Sobering Support Center also submits data to the TARGET system, those data are not used in this report because only minimal TARGET data are collected for sobering services.)

## Race/Ethnicity/Hispanic Origin Data Issues

Among the programs that are included in this report, there are a number of differences in how data about race, ethnicity, and Hispanic origin are collected and/or reported. To combine the data into a single consistent format, the following decisions were made:

- The "race/ethnicity" data reported for all program areas is presented using a single set of categories.
- The categories chosen are four commonly identified broad "race/ethnicity" groups (Black/African American, White/Caucasian/European American/Middle Eastern, Asian/Pacific Islander, and Native American/Alaska Native) and two other groups (Multi-racial and Other/Unknown).
- In those areas where the data collection system allowed more than one choice per person, any individual with data that "rolled up" into two or more different broad groups is counted as "Multi-racial" (White and Chinese, which rolled up to White and Asian-Pacific Islander, is counted as "Multi-racial"; Korean and Chinese as "Asian-Pacific Islander").
- "Other" is grouped with "Unknown" into "Other/Unknown."

## Program-Specific Data Notes

### *Emergency Services Patrol*
Individually identified data are not currently collected for this service.

### *Sobering Center (Dutch Shisler Service Center)*
Data for services are entered into the MHCADSD chemical dependency database by sobering support center staff using the Sobering Center application.

### *Detoxification Center*
Data for services at the Detoxification Center are entered into the TARGET data system by Detoxification Center staff. This report is based on downloaded data from that system.

A separate TARGET admission is reported for each level of care. To represent the true volume of admissions regardless of changes in level of care, only one admission is counted when a person had a prior TARGET detoxification admission that ended the day before the new TARGET admission date.

TARGET requires that data be reported about each person's "primary substance used" as reported by the person admitted and evaluated by the clinician. The Detoxification Center is not required to report data about the drug(s) for which the person is receiving detoxification services.

### *Involuntary Commitment Services*
Data for Involuntary Commitment Services (ICS) referrals are entered into the integrated chemical dependency database by ICS staff using the ICS application. Data included are for referrals received and the disposition of referrals.

### *Outpatient Treatment: Youth, Adult, and Opioid Treatment Programs*
Data for all Outpatient programs are entered into the TARGET system by service providers; the Substance Abuse Prevention and Treatment Annual Report is based on those data.

The data used in this report are limited as follows:

- Only admissions where the TARGET "Fund Source" is "County Community Services" or there was a King County "Special Project Code" at some time during the admission are included. These conditions include admissions funded by MIDD. Those data indicate that the services are provided under contracts with King County.

- Data included for Youth and Adult are for the TARGET modalities of intensive outpatient and outpatient. Data for Youth are for all admissions where the client was under 18 years old on the admission date (for Adult, 18 years or over).

- Data for Opioid Treatment Programs are for all admissions where the TARGET modality is "Methadone/Opiate Substitution Treatment."

- Opioid Treatment Program admissions that were essentially transfers to another treatment location (often with the same provider) were combined. Such continuous treatment episodes were counted as a new admission only for the period when the first admission started and were counted as only one admission for any period in which the combined admissions were open.

The treatment retention rate is based on all admissions that started during a report period. If the discharge date minus the admission date is greater than 90 days, or the admission has not yet ended (no discharge date), it is counted as retained 91 or more days. The count of those admissions each biennial quarter is divided by the count of all admissions that started in the biennial quarter to calculate the percentage shown. This algorithm is different from the DBHR measure that also uses treatment activity data and discharge reasons to categorize the admissions counted for a retention rate.

# Appendix B. Glossary

| | |
|---|---|
| A-CRA | Adolescent Community Reinforcement Approach |
| AAFT | Assertive Adolescent and Family Treatment Project |
| ACA | Affordable Care Act |
| ACC | Assertive Continuing Care |
| ADATSA | The Alcohol and Drug Addiction Treatment and Support Act, which provides state-financed treatment and support to indigent people who are chemically dependent. ADATSA provides eligible people with inpatient and outpatient chemical dependency treatment and with limited financial support for housing and other needs. |
| AODPP | Alcohol and Other Drug Prevention Program |
| ATR | Access to Recovery |
| Biennial Quarter | Biennial quarters are one fourth of a biennium (two-year period), or six months long. Biennial quarters in this report are the first half of the calendar year and the second half of the calendar year. |
| Biennium | Washington State's fiscal year is organized on a two-year basis, referred to as a biennium. The last biennium included in this report began July 1, 2013 and will end June 30, 2015. |
| CD Tx | Chemical Dependency Treatment |
| CDP | Chemical Dependency Professional |
| CDPT | Chemical Dependency Professional Trainee |
| CRA | Community Reinforcement Approach |
| DBHR | Washington State Division of Behavioral Health and Recovery |
| EBP | Evidence-Based Practice |
| ESP | Emergency Services Patrol |
| GAIN | Global Appraisal of Individual Needs; A standardized bio-psychosocial assessment tool for people presenting for substance abuse treatment. |
| GAIN-I | The GAIN instrument used for an initial comprehensive assessment. |
| GAIN-M90 | GAIN Monitoring 90 Days. A quarterly follow-up for monitoring how participants respond to treatment and/or do after they have been discharged. |
| GAIN-SS | GAIN Short Screener. A quick tool used to screen for mental health and substance |

| | |
|---|---|
| | use diagnoses. |
| ICS | Involuntary Commitment Services (see program description) |
| JDCEP | King County Juvenile Drug Court Enhancement Project |
| KCCOP | King County Community Organizing Program |
| MHCADSD | The Mental Health, Chemical Abuse and Dependency Services Division of the King County Department of Community and Human Services. |
| MIDD | The Mental Illness and Drug Dependency Action Plan is a King County initiative funded with a one tenth of one percent sales tax to provide programs designed to stabilize people suffering from mental illness and chemical dependency, and to divert them from jails and emergency rooms by getting them proper treatment. |
| OTP | Opioid treatment program (see program description) |
| PHSKC | Public Health – Seattle & King County |
| PRI | Prevention Redesign Initiative |
| ROSC | Recovery-Oriented System of Care |
| SA | Substance Abuse |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SBIRT | Screening, Brief Intervention, and Referral to Treatment |
| SUD | Substance Use Disorder |
| TARGET | Treatment Assessment and Report Generation Tool is a data collection and reporting system maintained by the Washington State Department of Social and Human Services and contains data submitted by contracted treatment providers about the publicly funded chemical dependency treatment that they provide. |
| TF-CBT | Trauma-Focused Cognitive Behavioral Therapy |
| WASBIRT-PCI | Washington Screening, Brief Intervention, Referral to Treatment – Primary Care Integration Project |

# Appendix C. Program Providers

| Provider | Prev. | ESP | DSSC | Detox | ICS | Outpatient | | OTP |
|---|---|---|---|---|---|---|---|---|
| | | | | | | Youth | Adult | |
| Asian Counseling and Referral Service | | | | | | x | x | |
| Auburn Youth Resources | | | | | | x | | |
| Catholic Community Services | | | | | | | x | |
| Center for Human Services | | | | | | x | x | |
| Community Psychiatric Clinic | | | | | | x | x | |
| Consejo Counseling and Referral Service | | | | | | x | x | |
| Downtown Emergency Service Center | | | | | | | x | |
| EvergreenHealth | | | | | | | x | |
| Evergreen Treatment Services | | | | | | | | x |
| Friends of Youth | | | | | | x | | |
| Harborview Medical Center Addictions Program | | | | | | | x | |
| Integrative Counseling Services | | | | | | x | x | |
| Intercept Associates | | | | | | | x | |
| Kent Youth and Family Services | | | | | | x | | |
| King County Emergency Services Patrol | | x | | | | | | |
| King County Involuntary Commitment Services | | | | | x | | | |
| Muckleshoot Indian Tribe | | | | | | x | x | |
| Navos | x | | | | | x | x | |
| Neighborhood House | x | | | | | | | |
| New Traditions | | | | | | | x | |
| Northshore Family and Youth Services | | | | | | x | | |
| Pioneer Human Services | | | x | | | | x | |
| Recovery Centers of King County | | | | x | | | x | |
| Renton Area Youth and Family Services | | | | | | x | | |
| SeaMar Community Health Centers | | | | | | x | x | |
| Seattle Counseling Service | | | | | | x | x | |
| Seattle Indian Health Board | | | | | | | x | |
| Seattle Public Schools | x | | | | | | | |
| Snoqualmie Indian Tribe | | | | | | x | x | |
| Sound Mental Health | | | | | | x | x | |
| Therapeutic Health Services | | | | | | x | x | x |
| Valley Cities Counseling and Consultation | | | | | | | x | |
| Vashon Youth and Family Services | x | | | | | x | x | |
| Washington Asian Pacific Islander Families Against Substance Abuse (WAPIFASA) | | | | | | x | | |
| Youth Eastside Services | | | | | | x | | |